BYLAWS, RULES, AND REGULATIONS

of the

MEDICAL STAFF

of

VETERANS AFFAIRS
PALO ALTO HEALTH CARE SYSTEM

3801 MIRANDA AVENUE
PALO ALTO, CALIFORNIA 94304

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TABLE OF CONTENTS

RULES AND REGULATIONS

PREAMBLE

The Veterans Affairs Palo Alto Health Care System, hereafter known as VAPAHCS, is a federal health care system, comprised of hospitals and outpatient clinics, operating under the general policies of the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA).

As in other VHA facilities, federal law and regulations provide for the legal accountability and responsibility of VAPAHCS and its Medical Staff to the patients they are charged to serve.

In contrast to organizational structures of health care institutions not operated by the federal government, VA Health Care System Medical Staff members are subject to policies and regulations issued by the VHA. As such, the Medical Staff of VAPAHCS does not organize itself, select its own Chief of Staff (COS), elect its Clinical Service Chiefs (CSCs) (equivalent to department chairpersons), nor determine structure and function of some of its main committees. Even so, members of the Medical Staff accept the responsibility for delivering quality patient care within the policies and regulations as required by VHA. Medical Staff decisions affecting organization and process are more in the nature of recommendations to the COS, the Performance Excellence Council, and/or the Governing Body.

The mission of VAPAHCS and its Medical Staff, as a general medical-surgical-psychiatric-rehabilitation health care institution, with ambulatory care and extended care services and community living centers, is to honor America's veterans by providing exceptional health care that improves their health and well-being. In addition to the clinical care, education, and research missions, VAPAHCS serves as a back-up medical facility to the Department of Defense in time of national emergency.

The graduate education and training programs and research are supervised and directed by the Health Care System Director (HCSD) through the Medical Staff as reflected in the affiliation agreements.

The Medical Staff has been delegated by the Governing Body the overall responsibility for the quality of medical care as delineated by specific clinical privileges. Individuals are accountable for keeping licensure current, providing evidence of relevant training and/or experience, and maintaining a health status that will not interfere with exercising those clinical privileges.

These Bylaws, Rules, and Regulations have been formulated and adopted to describe the professional structure and function of the Medical Staff of VAPAHCS and to permit self governance to the greatest extent possible, within the operating framework of the policies of VAPAHCS and VHA, in order for the Medical Staff to properly discharge its responsibilities in helping the health care system achieve its mission.

DEFINITIONS

1. HEALTH CARE SYSTEM means Veterans Affairs Palo Alto Health Care System. It is a three division health care system with hospitals and clinics at Palo Alto, Menlo Park, and Livermore. Community based outpatient clinics are located in Monterey, San Jose, Stockton, Modesto, Sonora, Capitola, and Fremont.

2. GOVERNING BODY is taken to mean the Under Secretary for Health to whom the Secretary of the Department of Veterans Affairs has delegated authority for administration of the Veterans Health Administration (VHA) of the Department of the Veterans Affairs (VA) of the federal government. For the purpose of local facility management and planning, the Health Care System Director functions as the representative of the Governing Body.

3. The HEALTH CARE SYSTEM DIRECTOR (HCSD), appointed by the Governing Body in consultation with the Secretary of the Department of Veterans Affairs, acts as its agent in the overall administrative management of the health care system and is therefore the "Governing Body" at VAPAHCS. The Chief Executive Officer (CEO) of the health care system is responsible to the Veterans Integrated Service Network (VISN) Director and the Under Secretary for Health.

4. The CHIEFS OF STAFF (COS) at VA health care facilities are appointed by the Under Secretary for Health of the VHA to an indefinite term. They are not elected by the Medical Staff. Their lines of authority, duties, and responsibilities are more nearly akin to that of a Medical Director in a non-VA health care system who is appointed by the Governing Body and whose primary responsibility is to the Governing Body.

5. The ASSOCIATE DIRECTOR acts in the capacity of the Chief Operations Officer.

6. The MEDICAL STAFF within the context of these Bylaws, Rules, and Regulations is not a self governing organization of the professional staff but is organized within VHA operational policies so its members may provide the highest quality of care within those policies. Members of the Medical Staff are defined as physicians (MD or DO), dentists, podiatrists, optometrists, and clinical psychologists (PhD).

7. The PROFESSIONAL STANDARDS BOARD (PSB) serves as the credentialing and privileging committee of the Medical Staff making recommendations to the Medical Executive Board on issues relating to employment (i.e., credentialing and privileging, grade, salary, and special advancement for performance) and scope of practice for certain allied health professionals.

8. The MEDICAL EXECUTIVE BOARD (MEB) is the executive committee of the VAPAHCS Medical Staff. It is the policy-making committee and is responsible for governance of the Medical Staff in contradistinction to the Governing Body of the health care system as defined in #2 above. The MEB is chaired by the COS and reports to the HCSD. Its members

include: all of the Deputy and Associate Chiefs of Staff; the Clinical Service Chiefs (CSC); the Allied Health Service Chiefs including: Audiology and Speech Pathology, Blind Rehabilitation, Pharmacy, Recreation Therapy, and Social Work. Designees or representatives may attend instead of the official member. The HCSD or Associate Director, Director for Clinical Support, Quality Management representatives, and Regional Counsel are ex-officio members.

9. The AFFILIATION COUNCIL is an advisory council to the HCSD and COS. It is established by a formal affiliation agreement between VAPAHCS and Stanford University School of Medicine. Its members are appointed by the HCSD from representatives of the affiliate and VAPAHCS to consider and advise on development, management, and evaluation of all educational and research programs conducted at the facility.

10. STAFF PRACTITIONER, as referred to in these Bylaws, Rules, and Regulations, is a physician (MD or DO), dentist, podiatrist, optometrist, or psychologist, who is fully licensed or otherwise granted authority to practice in any one or more of the States, Territories, or Commonwealths of the USA and/or the District of Columbia. These physicians, dentists, podiatrists, optometrists, or psychologists have met VHA standards for appointment and are thereby granted specific privileges to independently attend patients and engage in health sciences education and/or biomedical research at VAPAHCS.

11. An APPOINTMENT to the Medical Staff will be based on having appropriate personnel appointment action to provide patient care services at this health care system. This process is distinct from, but may overlap, that described for the granting of clinical privileges in #12 below.

12. Having CLINICAL PRIVILEGES or being PRIVILEGED means individually specific permission has been granted to a Medical Staff member to provide patient care services including access to resources of VAPAHCS (equipment, facilities, personnel, etc.) considered necessary to exercise those privileges.

13. Medical Staff YEAR follows the federal fiscal year commencing October 1 and ending the following September 30.

14. RESIDENTS or FELLOWS are individuals who are engaged in a postgraduate training program in medicine (including all specialties), dentistry, podiatry, or psychology, who participate in patient care under the direction of staff practitioners. Such programs must be accredited by the Accrediting Council of Graduate Medical Education (ACGME), American Dental Association (ADA), American Podiatric Medical Education (APMA), or American Psychological Association (APA).

15. MAJOR HIGH-RISK diagnostic or therapeutic interventions are defined as the procedures that require conscious sedation, anesthesia or analgesia, or are likely to produce significant discomfort, morbidity, or mortality.

ARTICLE I MEDICAL STAFF ORGANIZATION

1.1 The Medical Staff is organized according to the standards, guidelines, regulations, and policies of VA and the regulations and policies of VAPAHCS. Being a member of the Medical Staff means holding an employee contract with VA with the understanding that in addition to providing high quality, safe patient care, the member will participate as assigned on boards and committees organized to promote such care.

ARTICLE II PURPOSE

The purpose of the Medical Staff is to:

2.1 Assign to the Medical Staff overall responsibility for the quality of all medical care provided to patients, the ethical conduct, and professional practices of its members, and accountability to the HCSD and VHA through the MEB and the COS;

2.2 Provide mechanisms that will assure each member is fully qualified at the time of initial appointment and reappointment to the Medical Staff. Assure the granting of specific clinical privileges and when reprivileging to maintain the optimal level of professional performance;

2.3 Create an atmosphere and framework through the Bylaws, within which each Medical Staff member can accomplish the Medical Staff functions and responsibilities in accordance with the standards set by VAPAHCS and The Joint Commission and by regulations of VHA;

2.4 Ensure that all patients with the same health problems will be provided with the same high level of care throughout VAPAHCS; that care will be delivered in the most appropriate, efficient, timely, and safe manner possible whether as an inpatient or outpatient; and that the care given will be subjected to continuous quality improvement practices;

2.5 Encourage continuous integration of high quality educational programs and advancement of scientific knowledge through research and learning, with the goal of continually improving the quality of patient care and continually advancing the professional skills of the Medical Staff.

ARTICLE III MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

3.1.1 Being on the Medical Staff at VAPAHCS is a privilege extended only to professionally competent physicians, dentists, podiatrists, optometrists, and clinical psychologists, who continuously meet the qualifications, standards, policies, and requirements of VAPAHCS, these Bylaws, Rules, and Regulations, and the regulations of VHA. Membership may be considered in the future for other licensed practitioners who are

permitted by law to provide patient care services independently and who meet the qualifications, standards, and requirements of the Bylaws, Rules, and Regulations of VAPAHCS and VHA.

3.1.2 No physician, dentist, podiatrist, optometrist, or psychologist, including those in administrative or research positions, shall by virtue of a contract with VAPAHCS alone, admit or provide medical or health-related services to patients in VAPAHCS unless granted emergency, temporary, or full privileges in accordance with the procedures in these Bylaws.

3.1.3 Qualifying for membership in the Medical Staff does not automatically grant clinical privileges.

3.2 QUALIFICATIONS OF MEDICAL STAFF MEMBERSHIP

Only those dentists, physicians, podiatrists, optometrists, or clinical psychologists qualify who:

3.2.1. Possess an active, current, full, and unrestricted license to practice medicine, dentistry, podiatry, optometry, or psychology in one of the States, Territories, or Commonwealths of the USA or the District of Columbia, as required for employment by VHA;

3.2.2 Document and provide copies of the needed original certificates or letters of support or signed statements to demonstrate:

3.2.2.1 Proof of US citizenship. A non-citizen must provide a valid visa and proof of qualification for a temporary appointment;

3.2.2.2 Claims of professional education, training, and subsequent experience, as being appropriate and acceptable for the position under consideration;

3.2.2.3 Current professional competence, sound judgment, and ability to work cooperatively with others so as not to adversely affect patient care;

3.2.2.4 Sufficient physical and mental health so as not to compromise their professional and ethical competence, thereby assuring that patients treated by them can reasonably expect to receive high quality medical care;

3.2.2.5 The ability and willingness to adhere to the ethics of their respective professions, including commitment to keep confidential all information and records received in the physician-patient relationship, as required by law; and

3.2.2.6 The ability and willingness to participate and properly discharge responsibilities as determined by the HCSD, the COS, the MEB, VHA regulations, and The Joint Commission standards, including participating in Quality Management activities.

3.2.3 In order for unlimited licensed practitioners (MDs and DOs) to be on the Medical Staff, they must hold a degree of doctor of medicine or osteopathy, or its equivalent, from a school approved by VHA's Under Secretary for Health for the year in which the course of study was completed.

3.2.4 Limited licensed practitioners on the Medical Staff (dentists, podiatrists, optometrists, or clinical psychologists) must hold the appropriate degree conferred by a school approved at the time of issuance by VHA's Under Secretary for Health for the year in which the course of study was completed.

3.3 EFFECT OF OTHER AFFILIATIONS

3.3.1 No person shall be entitled to exercise any clinical privileges merely by virtue of licensure to practice in this or any other State, membership in any professional organization, certification by any clinical examining board, having clinical privileges or staff membership at another health care facility, such as the primary affiliate, or exercising privileges in another practice.

3.4. NONDISCRIMINATION

3.4.1 The professional criteria cited above under Article III, section 3.2 will be uniformly applied to all applicants or members and shall constitute the basis for the granting of clinical privileges without discrimination for such reasons as sex, race, creed, national origin, age, marital status, membership or non membership in a labor organization, lawful partisan, and political affiliation, or for reason of any physical handicap, when the handicapped employee is otherwise qualified and capable of providing high quality patient care and treatment.

3.5 RESPONSIBILITIES OF THE MEDICAL STAFF

The ongoing responsibilities of each member of the Medical Staff include:

3.5.1 Providing patients with the highest quality of health care consistent with the high professional standards expected of all others of the Medical Staff of VAPAHCS;

3.5.2 Abiding by the current Bylaws, Rules, and Regulations of VAPAHCS and other regulations (e.g., Policies, Procedures, and Directives), which may be issued from time to time by VHA;

3.5.3 Discharging in a responsible and cooperative manner such responsibilities and assignments imposed upon the member by the HCSD, COS, or MEB;

3.5.4 Preparing and completing medical records as per VAPAHCS written policy for all patients to whom the member provides care in this health care system (refer to Rules and Regulations, Section R.12, Medical Records);

3.5.5 Following the ethical standards expressed in Article VI;

3.5.6 Participating in Office of Quality Management activities concerned with patient care;

3.5.7 Aiding and participating in education programs for medical students, resident physicians, resident dentists, resident podiatrists, resident psychologists, optometry residents, and any other learning activities of students in the health sciences and in continuing education programs organized for staff physicians and dentists, nurses, and other personnel, as deemed necessary;

3.5.8 Working cooperatively with Medical Staff members, nurses, hospital administrative personnel, and others;

3.5.9 Providing for continuous care of patients assigned to their care during any absences by making appropriate arrangements for coverage for those patients;

3.5.10 Participating in such emergency coverage or consultation as determined by the Medical Staff, the COS, or requested by the HCSD;

3.5.11 Discharging such other staff obligations as may lawfully be established by the Medical Staff, CSC, COS, or HCSD;

3.5.12 Providing information to the COS, HCSD and/or legal counsel regarding any matter under investigation pertaining to patient care in the health care system or outside professional activity locations. The minimum requirement of the latter is information on final judgments or settlements of professional liability actions;

3.5.13 For those of the Medical Staff who provide service under scarce medical specialty contracts, providing evidence of current professional liability insurance, as required by federal and VA contract requirements; and

3.5.14 Caring for patients in a manner consistent with the "Rights of Patients" published by VA in the Federal Register. The Patients' Rights and Service Standards are posted throughout various areas of VAPAHCS.

ARTICLE IV APPOINTMENT AND REAPPPRAISAL/REPRIVILEGING

4.1 GENERAL

4.1.1 All potential members of the Medical Staff, as defined in 5.1.2 below, who expect to hold clinical privileges, will be subjected to full credentials review at the time of appraisal for initial appointment and will be fully reappraised at the time of reprivileging. Similar review will be made for the initial granting of clinical privileges and after a break in service of more than 15 workdays as outlined in this Article. Credentials that are subject to change during leaves of absence will be subjected to review at the time the individual returns to duty.

4.1.2 Except as otherwise specified, no one shall exercise any clinical privileges in this health care system until that person becomes a member of the Medical Staff as set forth in these Bylaws. By applying for privileges, the applicant acknowledges responsibility to review these Bylaws, Rules, and Regulations and accept the responsibilities of being a Medical Staff member and comply with the Bylaws, Rules, and Regulations as they exist and as they may be modified. Only such clinical privileges that have been granted may be exercised.

4.1.3 Appointments to the Medical Staff are conditional, pending appointments to VA service on completion of contractual agreements for medical services. The authority for these appointments is based upon:

4.1.3.1 Provisions of 38 U.S.C. in accordance with VA, VA Handbook 5005, Part II, and applicable Agreement(s) of Affiliation enforced at the time of appointment and

4.1.3.2 Provisions of federal and VA acquisition requirements for scarce medical specialty contracts.

4.2 PERIOD OF APPOINTMENT

4.2.1 Initial appointments to VA employment made under authority of 38 U.S.C. 7401 (1) and 7405 (a) (1) are made in accordance with regulations stated in VA Handbook 5005, Part II, Chapter 3. Only full-time permanent appointments of physicians, dentists, podiatrists, and optometrists are made under authority of section 38 U.S.C. 7401 (1). These appointments are subject to a two-year probationary period requirement. Temporary full-time appointments are made under authority of section 38 U.S.C. 7405 (a) (1). Temporary full-time appointments may be made for any period up to 3 years. Such appointments may be renewed, but the aggregate period of temporary service normally will not exceed 6 years. The HCSD may grant exceptions to permit renewals beyond 6 years when this type of appointment best meets the needs of the VA medical program. During this time, the appointee's professional competence, performance, and conduct will be evaluated by the appropriate CSC, COS, and MEB. If the applicant has demonstrated an acceptable level of performance and conduct, permanent appointment may be granted.

4.3 BURDEN OF PRODUCING INFORMATION

4.3.1 In connection with all applications for appointment and reappointment, the applicant shall be responsible for producing the information required for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges requested, resolving any reasonable doubts about these matters, and satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a physical examination and may include a psychological examination, if deemed appropriate by the PSB.

4.4 APPOINTMENT AUTHORITY

4.4.1 Appointments, denials, and revocations of appointments to the Medical Staff shall be made by the HCSD, upon recommendation from the MEB.

4.5 APPLICATION PROCEDURE AND REQUIRED DOCUMENTS

4.5.1 All applicants will:

4.5.1.1 Sign a "Consent for the Release of Information" permitting VHA to obtain information from past employers, schools, etc.;

4.5.1.2 Allow for inspection by health care system representatives of pertinent records and documents that are material to an evaluation of the applicant's professional and ethical qualifications and ability to carry out the clinical privileges requested;

4.5.1.3 Grant permission for consulting by health care system representatives with others who have been associated with the applicant and/or who may have information bearing on the applicant’s competence and qualifications;

4.5.1.4 Sign an ethical pledge to abide by practices described in Article VI and such other forms and certifications required by VHA regulations;

4.5.1.5 Provide any information regarding current professional liability insurance and any past or present involvement in professional liability action, whether any claim has been made against the practitioner in the practice of any health occupation and the status of the claim, and whether a complaint or report has been filed with any state medical licensing or disciplinary agency, such as a local or state medical society, state disciplinary body, professional or specialty association, or state/federal agency;

4.5.1.6 Be prepared to submit to random drug testing;

4.5.1.7 Comply fully with the policy and procedures of the Heath Care System Memorandum (HCSM), titled "Credentialing and Privileging of Physicians, Dentists, Podiatrists, Optometrists, and Psychologists"; and

4.5.1.8 Be provided with a current copy of the Medical Staff Bylaws, Rules, and Regulations. Each applicant shall sign a statement acknowledging that the applicant has read and agrees to be bound by the Medical Staff Bylaws, Rules, and Regulations.

4.6 APPOINTMENT PROCESS

4.6.1 CLINICAL SERVICE CHIEF (CSC) RESPONSIBILITY

4.6.1.1 The CSC is responsible for recommending the initial appointment of all providers of clinical care on the CSC's service.

4.6.1.2 Application for appointment shall be submitted to the COS's office by the CSC for review and to ensure all appropriate documents, certifications, and signatures have been obtained and are in accordance with the Bylaws, Rules, and Regulations and VHA regulations.

4.6.1.3 If deemed appropriate by the CSC and the COS, the CSC will arrange interviews of the applicant with the CSC, COS, HCSD, or representatives from Stanford.

4.6.1.4 The CSC with the COS, as appropriate, shall select an applicant to fill a vacant position based on review and evaluation of the credentials of all applicants, consultation with other individuals who have interviewed the applicants, and consideration of the ability of the health care system to provide adequate facilities and support services.

4.6.2 CHIEF OF STAFF (COS) RESPONSIBILITY

4.6.2.1 Within 30 days or as soon thereafter as possible, when all necessary documents have been provided, the COS shall review the application and related documents and, if deemed necessary, shall interview the applicant. The COS shall arrange interviews of CSC applicants with the HCSD, ACOS for Education, Dean of Stanford University School of Medicine, as appropriate, and such other members of the health care system staff, as necessary.

4.6.2.2 After a final decision is made to select a candidate for appointment to the Medical Staff, the candidate's name will be forwarded to the Medical Staff Office (MSO).

4.7 APPOINTMENT ACTION

4.7.1 The appointment process shall be accomplished expeditiously:

4.7.1.1 For all applicants for appointment to the Medical Staff, the appropriate CSC, in coordination with the MSO, shall promptly submit the applicant's complete file,

including application form, letters of recommendation, and curriculum vitae, together with a recommendation to the COS for concurrence and presentation to the PSB and subsequently to the MEB. The PSB shall evaluate the applicant's credentials, application for privileges, staff assignment(s), and recommendations of the CSC, and recommend, with the concurrence of the MEB, their approval or disapproval of membership to the Medical Staff. The PSB shall determine the grade/step of the applicant and the date employment commences at VAPAHCS. Following concurrence by the MEB, the COS shall promptly submit the recommendations to the HCSD, along with the applicant's complete file, for review and approval. Following receipt of the complete file, the HCSD shall, within 45 days, submit the file to Human Resources Management Service (HRMS), who shall advise the applicant as to the reporting date and procedures to follow in reporting for duty, and shall complete the appointment process.

4.7.1.2 HRMS will send letters of appointment to applicants after final approval by the PSB, MEB, COS, and HCSD. Decisions of the PSB, MEB, COS, and/or the HCSD that are adverse to the applicant shall be handled through the CSC.

4.7.1.3 When, in the opinion of the HCSD and COS, there has been an unwarranted delay in the appointment process (more than 45 days after all required information has been obtained), they may act on an individual's appointment status without specific recommendations of the CSC, employing the information available to them. Prior to taking such action, the HCSD and COS shall notify the CSC of their intent and shall designate an action date prior to which the CSC may still fulfill the CSC's responsibility or give cause for inaction.

4.7.1.4 A separate credentialing and privileging file for each Medical Staff member will be established and maintained. These files will be the responsibility of the COS and will contain documents relevant to credentialing and privileging. At any time the file is found to lack required documentation for any reason, efforts will be made to obtain the documentation. When it is not possible to verify required information, all efforts will be documented in the credentialing and privileging file. This information is maintained in the MSO.

4.7.1.5 Approved clinical privileges documents are placed in the individual practitioner's privileging folders. Copies are distributed to the practitioner and CSC.

4.7.1.6 Appointment requirements for administrative positions (e.g., CSC, COS) exceed the appointment requirements for other Medical Staff members. Physicians holding administrative positions must become members of the Medical Staff. If they participate in patient care in any way, they must be credentialed, re-credentialed, privileged, and re-privileged, as appropriate.

4.8 TERM OF APPOINTMENT AND CONTINUATION OF APPOINTMENT

4.8.1 The term of the initial appointment to the Medical Staff shall be governed by VHA regulations for employment. Continuation of that appointment to the Medical Staff shall be subject to demonstrated current competence. Reappraisal shall be completed at least every two years in accordance with the process described in Article VIII, paragraph 8.3.

4.8.2 Personnel policies of the Department of Veterans Affairs for contract employment require that Consultant and Attending (C&A) staff be reappointed annually; however, their reappraisal/re-privileging need to be completed only every two years and will follow a process similar to other appointments to the Medical Staff. Appointment and reappointment of the C&A staff shall be based on demonstrated current competence of the individual in accordance with the reappraisal process described in Article VIII, paragraph 8.3.

ARTICLE V CATEGORIES OF MEDICAL STAFF MEMBERSHIP

5.1 MEDICAL STAFF CATEGORY DEFINITIONS

5.1.1 The Medical Staff at VAPAHCS is categorized in two ways, namely by employment status and by function. Employment status alone does not confer Medical Staff membership although it may influence it.

5.1.2 By employment status, the Medical Staff members (physicians, dentists, podiatrists, optometrists, and psychologists) are classified into: permanent full-time, temporary full-time, part-time, intermittent, consultant and attending, without compensation (WOC), on-station fee basis, on-station contract, or on-station sharing agreement.

5.1.3 By function, members of the Medical Staff are appointed as:

5.1.3.1 Active staff who may be employed as permanent full-time, part-time, temporary full-time, or intermittent; and

5.1.3.2 Housestaff who are Interns, Residents, and Fellows, and are in a special category of the Medical Staff.

5.1.4 Medical staff are employed under Title 38. Termination of employment results in automatic termination of appointment to the Medical Staff, unless requested by the CSC to convert to another status (e.g., Consultant, Fee Basis, etc.).

5.2 ACTIVE STAFF

5.2.1 Medical Staff members holding administrative positions (e.g., CSCs and the COS) are subject to actions by the MEB in the same manner as all other staff. Active staff perform all significant Medical Staff organizational and administrative functions consistent with these Bylaws, Rules, and Regulations, VHA regulations, and other VAPAHCS policies. Consultants and Attendings, as defined in 5.1.2, are members of the active staff who supplement the full-time, part-time, and intermittent staff members in their roles in patient

care, education, and research. The credentialing and privileging process is the same as for other members. However, because of extensive responsibilities at their primary institutions, in most cases, Consultants and Fee-Basis physicians are not required to attend the same percentage of service meetings or provide the same service on committees as full-time staff.

5.2.2 QUALIFICATIONS

The active staff shall consist of physicians, dentists, podiatrists, optometrists, or clinical psychologists who:

5.2.21 Meet the general qualifications for membership set forth in Article III and have the appropriate employment status, as defined by VHA regulations; and

5.2.2.2 Have residences or have made living arrangements while on call, which in the opinion of the MEB, are close enough to VAPAHCS to provide appropriate continuity of care.

5.2.3 PREROGATIVES

Except as otherwise provided within these Bylaws, the prerogatives of an active staff member shall be to:

5.2.3.1 Exercise such clinical privileges as are granted pursuant to Article VIII and

5.2.3.2 Attend and have the right to vote, within the constraints of VHA regulations and commensurate with these Bylaws, Rules, and Regulations, and other policies of VAPAHCS, on matters presented at general and special meetings of the Medical Staff and of the service and committees of which the Medical Staff member is an appointed member.

5.3 HOUSESTAFF

5.3.1 The Housestaff are in a special category of the Medical Staff and shall consist of those individuals who are graduates of medical, osteopathic, dental, podiatric, or psychology schools and who are engaged in a formal program of postgraduate training and education at VAPAHCS, whether their employment contract is with or without compensation. They are recommended for their appointment by the clinical department of the appropriate affiliate. They are subject to the regulations of VHA for the VA portion of their training. They are not subject to a determination of clinical privileges, except as noted below in paragraph 5.3.2. They function only under the supervision of, and within the clinical privileges granted to, the Medical Staff member who has clinical privileges in the area being supervised and is a member of the Medical Staff. Unless specifically included as a voting member, Housestaff will serve as ex-officio members on designated health care system committees.

5.3.2 When a resident or fellow is in the advanced years of training, is a Chief Resident who normally supervises more junior residents, or functions outside of the normal training assignment (e.g., is hired to cover the Emergency Department as an independent practitioner), the resident or fellow must go through the credentialing and privileging process described in Article IV and become a member of the Medical Staff.

5.4 AFFILIATES OF THE MEDICAL STAFF

5.4.1 Allied health professionals may become affiliates of the Medical Staff (See Article VII). As such, they are not members of the Medical Staff.

ARTICLE VI ETHICS AND ETHICAL RELATIONSHIPS

6.1 GENERAL ETHICAL CONSIDERATIONS

6.1.1 All members of the Medical Staff will deliver patient care according to ethical practices outlined by VHA, the American Medical Association, the American Osteopathic Association, the American Dental Association, the American Podiatric Medical Association, the American Optometric Association, or the American Psychological Association, whichever is appropriate.

6.2 FULL-TIME APPOINTMENTS AND OUTSIDE PROFESSIONAL ACTIVITIES RESTRICTIONS

6.2.1 According to VA regulations, no full-time member of the Medical Staff may tender professional service for remuneration to any patient hospitalized or treated at VHA expense in a non-VA hospital, clinic, or other health care facility. Full-time professional staff who engage in outside professional activities for remuneration must scrupulously avoid creating any situation or circumstance where it might be implied that the employee, because of outside activity, is not meeting the full requirements and responsibilities of the VHA position. Consequently, Title 38 VHA full-time professional staff members who engage in outside professional activities for remuneration will be required to perform a scheduled tour of duty of 80 hours per pay period, while so involved, and meet other patient care needs which require their attendance beyond the scheduled tour of duty.

ARTICLE VII ALLIED HEALTH PROFESSIONALS (AHP)

7.1 GENERAL

7.1.1 Many different professionally trained people contribute their unique skills to the direct care of patients. Their activity is under the general supervision or direction of Medical Staff members. These individuals are generally, and for the purposes of these Bylaws, designated as Allied Health Professionals (AHPs). They shall be affiliate members of the Medical Staff and include, but are not limited to, the following:

Dental Hygienist

Certified Registered Nurse Anesthetist (CRNA)
Registered Nurse Practitioner (RNP)
Physician Assistant (PA)
Clinical Pharmacy Specialist (CPS)
Clinical Nurse Specialist (CNS)
Clinical Social Worker
Psychologist (Master's Level)
Dietitian
Audiologist
Speech Pathologist
Expanded Scope Registered Nurse (ESRN)

7.2 QUALIFICATIONS OF AHP's

7.2.1 Allied health professionals shall be subject to the qualification requirements contained in VHA and/or Office of Personnel Management regulations. Their responsibilities may be described in a position description, under a scope of practice, or in a functional statement.

7.2.2 Training, experience, and current and continuing competence qualify them as allied health professionals and shall be sufficient to permit them to:

7.2.2.1 Exercise judgment within their areas of competence, providing that a member of the Medical Staff shall have the ultimate responsibility for patient care;

7.2.2.2 Participate directly in the management of patients under the supervision or direction of a physician member of the Medical Staff;

7.2.2.3 Make entries in patients' medical records within the limits established by the Medical Staff; and

7.2.2.4 Prescribe medications under the supervision of a physician member of the Medical Staff; this applies only to appropriately approved RNPs, CRNAs, CPS's, and PAs.

7.3 APPOINTMENT OF AHPs

7.3.1 Allied Health Professionals shall be appointed in accordance with these Bylaws and the HCSMs relevant to AHPs.

7.4 RESPONSIBILITIES OF AHPs

Each allied health professional shall:

7.4.1 Meet the basic requirements of the appropriate position description, scope of practice, or functional statement;

7.4.2 Retain appropriate responsibility, within the areas of professional competence, for the care and supervision of patients assigned, or arrange a suitable alternative for such care and supervision;

7.4.3 Attend meetings of the assigned service, serve on health care system or Medical Staff committees as designated, and participate, as appropriate, in the Quality Management initiatives of this health care system;

7.4.4 Supervise professional appointees of the same profession, as appropriate;

7.4.5 Discharge other staff functions, as may be required from time to time by the Medical Staff, CSC, COS, or HCSD;

7.4.6 Be individually assigned to the appropriate service(s) at VAPAHCS and carry out their activities subject to the policies and procedures of VAPAHCS; and

7.4.7 Allied health professionals who have duties that constitute the practice of medicine (e.g., writing prescriptions for non "over the counter" medications, administering regional or general anesthesia, suturing or debridement of wounds, etc.) require a scope of practice that is signed by a physician supervisor and reviewed every two years by the PSB.

ARTICLE VIII CLINICAL PRIVILEGES

8.1 RESTRICTIONS OF CLINICAL PRIVILEGES

8.1.1 All members of the Medical Staff shall be allowed to perform only those diagnostic or therapeutic procedures for which they are considered by their professional peers to be competent to perform. Clinical privileges shall be granted on the basis of the individual's training, experience, and demonstrated current competence, judgment, and character.

8.1.2 The exercise of clinical privileges within any service shall be restricted by and subject to the rules and regulations of that service(s) and the authority of the CSC, PSB, and MEB.

8.2 INITIAL DETERMINATION OF CLINICAL PRIVILEGES

8.2.1 Every applicant requesting clinical privileges must complete the privileges form of the service assigned. The applicant shall have the burden of establishing qualifications and competency in the clinical privileges requested, this includes undergoing a Focused Professional Practice Evaluation (FPPE), which evaluates competency in performance of assigned duties (Refer to "Credentialing and Privileging of Physicians, Dentists, Podiatrists, Optometrists, and Psychologists. The CSC shall review the applicant's credentials and requested privileges and submit them with the CSC's recommendations to the PSB for evaluation. Evaluation by the PSB of such requests shall be based upon the applicant's

education, training, experience, demonstrated competence, references, and other relevant information. The PSB shall recommend action of appropriate clinical privileges to the MEB, COS, and HCSD. The HCSD's approval of the requested privileges constitutes approval.

8.3 REDETERMINATION OF CLINICAL PRIVILEGES

8.3.1 Redetermination of clinical privileges is based on an overall reappraisal considering the following factors: current review of all licenses from all states and Drug Enforcement Administration (DEA) registration review; National Practitioner Data Bank (NPDB) query; a statement of current health status with affirmation by the CSC or COS; adequate continuing education activity (18 hours of CME for clinical psychologists and 25 hours of Category I CME per calendar year or 100 hours of Category I CME within the last four years for all other members); the CSC's assessment and peer evaluations of care provided (e.g., Semi-Annual Service Specific Ongoing Professional Practice Evaluation (OPPE)/FPPE, as established in the HCSM, "Credentialing and Privileging of Physicians, Dentists, Podiatrists, Optometrists, and Psychologists"); peer review of the medical records of patients treated; findings of the Medical Staff committees which monitor the quality and appropriateness of patient care, including judgment and clinical or technical skills (results of quality management activities); timeliness of medical record completion; and a review of patient care events that may have led to claims filed in the last two years. Based on the PSB's and MEB's recommendations, the HCSD may approve or disapprove the renewal of clinical privileges within sixty days after receiving the request for renewal and before the lapse of the previous clinical privileges.

8.3.2 An effort will be made by the MSO personnel to verify all credentials claimed. A good faith effort to verify is defined as a documented telephone call that includes date, time, by whom the call was made, and who was contacted, a copy of the registered letter sent, or a copy of a fax sent.

8.4 CHANGES IN DELINEATED CLINICAL PRIVILEGES

8.4.1 MODIFICATION, ENHANCEMENT, OR EXPANSION - A staff member may request an increase in clinical privileges if the member believes such a change is warranted as a result of additional training, experience, or change in circumstances. The process is initiated by submitting a new completed privileging request form with supporting documentation to the appropriate CSC. The procedures specified in 8.3 above, where applicable, are then followed to obtain approval of the new set of clinical privileges. A period of proctoring (Refer to 8.9) with a member of the Medical Staff or with some other professional, as determined by the CSC or COS, may be necessary if clinical privileges are expanded.

8.4.2 REDUCTION OR TERMINATION - Privileges may also be reduced or terminated if Medical Staff members make formal requests for such reductions or termination and give full explanations why such requests should be granted. Medical Staff members who fail to maintain the required degree of competency, in accordance with paragraphs 8.1 - 8.3 of

this Article in these Bylaws and VA regulations, may have their clinical privileges reduced through actions of the COS in emergency circumstances, PSB, MEB, or HCSD. Emergency actions taken by the COS will be submitted for review to the PSB, MEB, and HCSD.

8.5 TEMPORARY AND DISASTER CLINICAL PRIVILEGES

8.5.1 Temporary appointment to the Medical Staff may be granted to a prospective Medical Staff member for a period not to exceed 45 working days. When the temporary appointment is for a disaster, it will be further limited to the period when there is an emergent or urgent patient care need. The temporary VA appointment is made under provisions of Title 38. The temporary appointment to the Medical Staff may be approved by the HCSD upon recommendation of the applicable CSC (or designated alternate) through the COS prior to receipt of all references or verification of other information and action by the MEB and PSB. Verification of licensure, confirmation of possession of clinical privileges comparable to those to be granted, initiation of NPDB query, and a reference will be obtained prior to making such an appointment. Additionally, for physicians, Federation of State Medical Boards (FSMB) screening will be initiated prior to appointment, or if that is not possible, on the next administrative workday.

8.5.2 The PSB and MEB will review the action at the next regularly scheduled meetings. When there is no immediate urgency to the granting of temporary privileges, the applicant's signed acknowledgment of having read these Medical Staff Bylaws, Rules, and Regulations and agreement in writing to be bound by their terms in all matters relating to the temporary clinical privileges, shall first be obtained before privileges are exercised. The recommendations of the CSC and COS shall be based on available information that reasonably supports a favorable determination regarding the qualifications, ability, and judgment of the applicant to exercise the privileges requested. If temporary clinical privileges are granted on the basis of general need rather than that of a specific patient situation, then there shall be designated supervision of the physician or dentist who is granted temporary clinical privileges pending the processing of an application for an appointment to a longer term. Temporary privileges may be terminated at any time by the COS alone or on recommendation of the CSC (or alternate). Any such actions must be submitted to the PSB or MEB for review. In this event, the CSC (or alternate) shall assign responsibility for the care of such terminated practitioner's patient(s) to other appropriate member(s) of the Medical Staff.

8.6 EMERGENCY PRIVILEGES

8.6.1 In the case of an emergency, any member of the Medical Staff shall be permitted and assisted to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by professional license and without regard to service status or clinical privileges. In so acting, the staff member is obligated to summon all available consultative aid deemed necessary. An "emergency" is defined as any condition in which serious permanent harm or aggravation of injury or disease could result to a patient or in which the life or limb of a patient is in immediate danger.

8.7 SPECIAL PRIVILEGE CONDITIONS FOR DENTISTS AND PODIATRISTS

8.7.1 Patients admitted for oral surgical, dental, or podiatric care shall receive the same basic medical appraisal as patients receiving other services. A physician member of the Medical Staff or designated member of the housestaff shall perform a history and physical (H&P) examination, evaluate the overall medical risk, and record the findings in the medical record. The dentist or podiatrist shall be responsible for that part of the H&P examination that is related to dentistry or podiatry, respectively. Surgical procedures performed by dentists or podiatrists in the operating room shall be under the overall supervision of the Chief, Surgical Service. Dental procedures performed outside of the operating room are under the overall supervision of the Chief, Dental Service. A physician member of the staff shall be responsible for the care of any medical problem that may be present or that may arise during the operative care of a dental or podiatric patient, and shall determine, with consultation if necessary, the overall risk assessment and effect of the operation on the patient's health.

8.7.2 Qualified oral and maxillofacial surgeons may admit patients without identified medical problems if they have been granted this specific privilege. An oral and maxillofacial attending must be available by beeper 24 hours per day while these patients are admitted. Patients with identified medical problems that require admission for care by an oral and maxillofacial surgeon must be admitted to a physician member of the Medical Staff with the oral surgeon participating in a consultative role. If a medical problem is identified after admission, care must be transferred to a physician member with full admitting privileges.

8.8 PRIVILEGES OF MEDICAL STAFF IN MORE THAN ONE SERVICE

8.8.1 When privileges are normally exercised in more than one service, the chiefs of each of the involved services shall rule on the appropriateness of such privileges before the recommendations are forwarded.

8.9 PROCTORING

8.9.1 Medical Staff members shall initially be proctored by a Medical Staff member for a period of time deemed appropriate by the relevant CSC. During that time the individual has provisional clinical privileges. Upon satisfactory completion of the proctoring period, the CSC will forward a recommendation to the PSB. After review by the MEB and approval of the HCSD, the individual will then have clinical privileges.

8.9.2 Proctoring may be waived upon request of the CSC if the applicant has demonstrated clinical competence in this area at our affiliated institution(s) or is a recognized expert in that field.

8.10 UNIFORMITY OF PRIVILEGING

8.10.1 Requirements and processes for requesting and granting privileges are the same for all practitioners who hold privileges regardless of discipline or position.

ARTICLE IX CORRECTIVE ACTION, FAIR HEARING, AND APPELLATE REVIEW

9.1 DENIAL OF MEDICAL STAFF APPOINTMENTS

9.1.1 When review of credentials and recommendations contained in a complete application results in the denial of appointment, the COS will notify the applicant through the CSC that the appointment has not been recommended and will briefly state the basis for the action. The applicant may ask for a fair hearing of the denial. Such a request must be submitted in writing to the HCSD within five working days of receiving the denial of the request for appointment to the Medical Staff.

9.2 REDUCTION OF CLINICAL PRIVILEGES FOR FULL-TIME PERMANENT STAFF

9.2.1 Reduction of privileges may include, but is not limited to, restricting performance of specific procedures or prescribing or dispensing controlled substances. Reduction of privileges may be time-limited or have restoration contingent upon fulfilling imposed conditions. Material which is part of a protected Quality Management review may not be used or disclosed in the course of action to reduce or revoke privileges; such material must be developed through independent means. Requirements of 38 U.S.C. are protective of full time permanent staff and therefore will likely result in duplicate hearings.

9.2.2 Revocation of privileges refers to the permanent loss of all clinical privileges.

9.2.3 When it is determined by the CSC that it is necessary to reduce or curtail any or all clinical privileges of a full-time permanent member of the Medical Staff on the basis of clinical performance, provider well-being, or other sound reasons, the CSC will submit a memorandum proposing reduction to the COS.

9.2.4 If the COS agrees with the proposed action, the full-time permanent member will receive written notice of the proposed changes in privileges from the COS. The notice will include a discussion of the reason(s) for the change in privileges and a statement of the member's right to be represented by counsel or a representative of the member's choice throughout the proceedings. The member will be allowed to review all evidence that is not restricted by regulation or statute upon which the proposed changes in privileges are based. Following that review, the member may respond in writing to the COS's written notice of intent. The member must submit the response within ten working days of receipt of the notice of intent from the COS. If requested by the member, the COS may grant an extension for a brief period not to exceed ten workdays except in extraordinary circumstances. All

information developed up to this point with respect to the proposed reduction of a member's privileges will be forwarded to the HCSD for a decision.

9.2.5 If the member disagrees with the HCSD's decision, a hearing may be requested. A member must submit the request in writing for a hearing within five workdays after receipt of the HCSD's decision. Upon receipt of a request for a hearing, the HCSD will appoint a review panel of three professionals within five workdays to conduct a review and hearing. If the member is a physician, at least two members of the review panel should be members of the PSB. In all cases, however, at least two members of the panel will be members of the same profession as the member seeking the hearing. During the hearing, the member has the right to be present throughout evidentiary proceedings, represented by counsel or a representative of the member's choice, to cross-examine witnesses and to purchase a copy of the transcriber's tape of the proceedings. The panel will complete its review and submit its report to the HCSD within 15 workdays. Additional time may be permitted by the HCSD for extraordinary circumstances or cause.

9.2.6 Upon receipt of the panel's report, the HCSD has the authority to accept, reject, accept in part, or modify the review panel's recommendations. The HCSD will issue a written decision within ten workdays of the day of receipt of the panel's report. If the member's privileges are reduced, the written decision will indicate the reasons for the change.

9.2.7 The full-time permanent member may submit a written appeal to the VISN Director within five workdays of receipt of the HCSD's decision. The VISN Director will provide a written decision based on the record within 20 workdays. The decision of the VISN Director is final.

9.2.8 A full-time permanent staff member may waive the right to a review panel hearing and, after the initial decision by the HCSD, may submit a written appeal to the VISN Director within five workdays after receipt of the initial decision by the HCSD; however, the review panel hearing as described above will be the only hearing process conducted in connection with the reduction of privileges. All other review processes will be conducted on the basis of the record.

9.2.9 Loss of partial or complete clinical privileges, including separation because of physical or mental disability, will be processed in accordance with federal law and VHA regulations. In the event of a possible agency-initiated disability retirement, representation will be allowed as provided by law.

9.2.10 If the COS agrees with the CSC's recommendation for revocation, the CSC will take appropriate measures to effect discharge of the full-time permanent employee or to separate a non-permanent employee. Such procedures will be conducted in a timely fashion and will be coordinated with the Chief, HRMS, or designee.

9.3 REDUCTION OF CLINICAL PRIVILEGES FOR PART-TIME MEDICAL STAFF

9.3.1 Part-time staff shall be accorded notice and hearing as set forth in preceding paragraphs 9.2.1 through 9.2.10, for reduction and revocation of staff privileges.

9.3.2 Loss of partial or complete clinical privileges, including separation because of physical or mental disability, will be processed in accordance with VHA regulations and local policy, as established in the HCSM, "Management of the Impaired Licensed Independent Practitioner." In the event of a possible agency-initiated disability retirement, representation will be allowed as provided by law.

9.3.3 Intermittent, WOC, temporary, and consulting staff are not subject to the hearing requirements to have appointment revoked.

9.4 MISCELLANEOUS PROVISIONS

9.4.1 Nothing in the procedures described in 9.1 or 9.2 restricts the authority of the HCSD, COS, or CSC to detail or reassign temporarily a member to non-patient care activities, thus suspending clinical privileges pending any proposed reduction of privileges, revocation of privileges, or discharge proceedings.

9.4.2 Actions taken to suspend clinical privileges will be submitted to the PSB and MEB for review.

9.4.3 Clinical privileges of a member of the Medical Staff may be suspended for major or intractable delinquencies of medical records or for failure to meet other professional obligations. However, those suspensions, unless temporary, must meet the requirements of 9.2 and 9.3 of this Article.

9.4.4 In the event a terminated health care professional is deemed to have significantly failed to conform to generally accepted standards of clinical professional practice during employment at VAPAHCS in such a way as to raise a reasonable concern for the immediate safety of patients outside of VAPAHCS, the Medical Staff member should be reported by the COS through the HCSD to the appropriate state licensing authority and the office of the Medical Inspector of the VA.

9.4.5 Disclosure of information to the NPDB through state licensing boards is required when an adverse action resulting in the reduction or revocation of clinical privileges exceeds 30 days.

9.4.6 Disclosure of information regarding malpractice payments determined by peer review to be related to professional incompetence or professional misconduct on the part of a VA professional will follow provisions of VHA policy dealing with the NPDB.

9.5 SUSPENSIONS

9.5.1 Summary suspension of privileges on a temporary basis may be made by the HCSD, on the recommendation of the COS, pending the outcome of a formal action or investigation when there is sufficient concern regarding patient safety or inappropriate practice patterns. The summary suspension pending investigation is not reported to the NPDB. Final action arising from the investigation following summary suspension that adversely affects privileges for a period longer than 30 days is reportable to the NPDB. When summary suspension is being considered, legal counsel will be advised and consulted. Legal counsel should be sought early when the performance of a member of the Medical Staff is such that, in the opinion of the CSC or a higher level supervisor, the Medical Staff member's continued exercise of clinical privileges would likely lead to serious harm to the patients.

9.5.2 Automatic suspension of clinical privileges shall occur whenever the license (or equivalent legal credential) of a Medical Staff member is revoked or restricted, or if the individual fails to renew the professional license prior to expiration. The automatic suspension shall be for the same time period that such license (or equivalent legal credential) is suspended. No right to a hearing or appellate review exists under these conditions.

9.5.3 Automatic suspension of the right to prescribe medications covered by a Drug Enforcement Agency (DEA) number will occur whenever a DEA number is revoked or suspended. The Medical Staff member is immediately and automatically divested of any right to prescribe medications covered by the DEA number. No right to a hearing or appellate review exists under this condition.

9.5.4 Medical Staff Members are held to the same high standards of conduct as all other staff. The most recent version of the "Intimidating and Disruptive and Behavior in the Workplace," Health Care System Memorandum spells out the expected code of conduct and applies fully to all members of the Medical Staff. Any staff member who fails to desist with such behavior after verbal or written counseling will be subject to further disciplinary action including potential suspension. Staff at any level who report intimidating or disruptive behavior or who cooperate with investigations of such behavior will be protected from discrimination and retaliation.

9.6 GENERAL

9.6.1 The Director, on behalf of the Health Care System and the Medical Staff, may cooperate with any State, Commonwealth, Territory or District of the USA licensing board or agency officially inquiring, in writing, into the professional performance history of a former member of the Medical Staff who is under the jurisdiction of such licensing board or agency; this includes a report concerning a former Medical Staff member whose professional medical practice so significantly failed to conform to generally accepted standards of medical professional practice as to raise reasonable concern for the safety of patients. In the absence of a request from such aforementioned licensing board or agency, however, the HCSD must obtain the approval of the Associate Deputy Under Secretary for Health and the Medical Inspector of the VHA prior to making a disclosure to the concerned licensing board or agency.

ARTICLE X ORGANIZATION OF THE MEDICAL STAFF

10.1 APPOINTMENT OF MEDICAL STAFF OFFICERS

10.1.1 In VAPAHCS, there are no "elected officers" of the Medical Staff. The COS and the CSCs are appointed to indefinite terms. Appointments of CSCs are submitted to VHA for information and comment; the COS's appointment must be approved by the Under Secretary for Health. Appointments are based on qualifications, training, and experience. The COS's appointment is for an indefinite period, and removal shall be subject to the approval of the VHA's Under Secretary for Health.

10.1.2 In VAPAHCS, the COS is the equivalent of the "Medical Director" or "President of the Medical Staff" and must be a member of the Medical Staff.

10.2 DUTIES AND RESPONSIBILITIES OF THE CHIEF OF STAFF (COS)

10.2.1 The COS will actively participate and support the health care system's performance improvement activities. The COS will ensure clinical services' involvement in these activities as well.

10.2.2 The COS shall serve as the Chief Executive Officer of the Medical Staff, organizing and presiding at meetings of the Medical Executive Board, annual meetings of the Medical Staff, and assuring that various other Medical Staff Committees and services are functioning in accordance with these Bylaws, Rules, and Regulations.

10.2.3 The COS shall act as full assistant to the HCSD and collaborate with the Associate Director in the planning, direction, coordination and supervision of administrative activities inherent in the care of patients, providing allied health services, and research and educational activities.

10.2.4 The COS shall enforce these Bylaws, applicable VHA regulations, and health care system policies, taking corrective action, as indicated.

10.2.5 The COS shall supervise and/or participate in the appointment and periodic reappraisal of members of the Medical Staff and allied health care staff, including credentialing and delineation of clinical privileges.

10.2.6 The COS shall represent the views, policies, needs and grievances of the Medical Staff to the governing body and to the HCSD.

10.2.7 The COS shall receive and interpret the policies of the governing body to the Medical Staff and report to the governing body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.

10.2.8 The COS shall represent the Medical Staff at the VISN level.

10.3 CLINICAL SERVICES

10.3.1 The Medical Staff is organized to carry out service under leadership of the service chief. Each of the services/programs listed below has a service chief/director, accountable to the COS. Each staff member shall be assigned to a specific service:

10.3.1.1 Anesthesiology Service
10.3.1.2 Dental Service
10.3.1.3 Dermatology Service
10.3.1.4 *Domiciliary Service
10.3.1.5 *Extended Care Service
10.3.1.6 Geriatric Research, Education and Clinical Center (GRECC)
10.3.1.7 *Medical Service (Ambulatory and Emergency Care)
10.3.1.8 Neurology Service
10.3.1.9 Nuclear Medicine Service
10.3.1.10 Pathology and Laboratory Medicine Service
10.3.1.11 *Psychiatry Service
10.3.1.12 Psychology Service
10.3.1.13 Radiology Service (*Interventional Radiology)
10.3.1.14 *Physical Medicine and Rehabilitation Service
10.3.1.15 *Spinal Cord Injury Service
10.3.1.16 *Surgical Service

*Bed Services

10.3.2 Each service will hold regularly scheduled meetings at least quarterly. They must be sufficiently frequent to carry out these functions:

10.3.2.1 Provide for continuous quality improvement within the service, including consideration of findings of ongoing monitoring and evaluation of quality (including access, efficiency, safety, and effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency privileges); patient satisfaction activities; risk management activities; and utilization management;

10.3.2.2 Assist in identifying important aspects of care for the service, identification of indicators used to monitor quality and appropriateness of important aspects of care, and evaluation of the quality and appropriateness of care;

10.3.2.3 Maintain records of meetings that include conclusions, recommendations, actions taken, and evaluations of actions taken. Minutes from these meetings are transmitted to the MEB, as appropriate;

10.3.2.4 Develop criteria for recommending clinical privileges for its members; and

10.3.2.5 Develop policies and procedures to assure effective management, ethics, safety, communication, and quality within VAPAHCS.

10.4 DUTIES AND RESPONSIBILITIES OF CLINICAL SERVICE CHIEFS (CSCs)

10.4.1 CSCs are qualified for their position by training, experience, and administrative ability, and shall be appointed for an indefinite period. CSCs must have certification by an appropriate specialty board or established comparable competence through the credentialing process. CSCs are appointed based on recommendations of the COS, HCSD, and representative from Stanford (when appropriate). Responsibilities of CSCs shall include:

10.4.1.1 Accountability to the COS and the HCSD for all professional and Medical Staff administrative activities within the service, including selection, orientation, and continuing education of the staff of the particular service;

10.4.1.2 Continuing surveillance of the professional performance of members of the Medical Staff who exercise privileges in their service, including recommendations on each member at the time of reappraisal;

10.4.1.3 Recommending to the PSB the criteria for granting privileges in the service and for recommending specific clinical privileges for each member of the service and others requesting privileges within the service;

10.4.1.4 Assuring that regular review and evaluation of the quality and appropriateness of patient care rendered within the service (including clinical work performed by staff members with privileges in the service who are assigned to another service) are carried out, documented, and reported in accordance with the health care system's Quality Management initiatives, VHA's Health Services Review Organization-Systematic Internal Review Program and, when applicable, The Joint Commission standards;

10.4.1.5 Assuring the participation of service staff members in appropriate continuing education programs and required meetings;

10.4.1.6 Appointing committees, as needed, to conduct service functions;

10.4.1.7 Participating in budgetary and staffing planning for the service, providing input for VAPAHCS's overall budgetary planning, and providing information or assistance for preparation of reports required by VHA and/or health care system policy;

10.4.1.8 Serving on the MEB and other committees as designated by the COS, and communicating actions taken by such committees to staff members of the CSC's service;

10.4.1.9 Designating appropriate service staff members to serve on Medical Staff committees commensurate with their clinical qualifications as requested by the MEB or the COS, and assuring their attendance and participation;

10.4.1.10 Representing service staff members at the HCSD's staff meetings and communicating items discussed to the service staff;

10.4.1.11 Taking or recommending actions necessary to assure service staff compliance with the Medical Staff Bylaws, Rules, and Regulations as well as VAPAHCS and VHA regulations and service policies, and assuring rules and regulations of the various services do not conflict with each other;

10.4.1.12 Coordinating the service's patient care activities with ancillary and administrative support services;

10.4.1.13 Fostering an atmosphere of professional decorum appropriate to the healing arts within the service;

10.4.1.14 Assessing and recommending to the COS off-site sources needed for patient care services not provided, or not accessible, on-site;

10.4.1.15 Ensuring the integration of the service into the primary functions of the organization and ensuring the coordination and integration of intradepartmental and interdepartmental services;

10.4.1.16 Recommending a sufficient number of qualified and competent personnel to provide care or service;

10.4.1.17 Determining the qualifications and competence of service personnel who are not independent practitioners and who provide patient care service;

10.4.1.18 Maintaining quality improvement programs, as appropriate;

10.4.1.19 Assuring the initial orientation and continuing education of all persons in the service; and

10.4.1.20 Recommending space and other resources needed by the service.

10.4.1.21 Develop policies and procedures to assure effective management, ethics, safety, communication, and quality within VAPAHCS.

10.5 AMBULATORY CARE, EXTENDED CARE, AND EMERCENCY SERVICES

10.5.1 Each physician providing care shall participate in quality management and other meetings of the service. Activities in ambulatory care and emergency medical services are all carried out under the direction of the Chief, Medical Service. Activities in extended care are all carried out under the direction of the Associate Chief of Staff (ACOS) for Extended Care. Emergency care physicians (including MODs) shall satisfy all requirements for Medical Staff membership.

ARTICLE XI COMMITTEES AND BOARDS

11.1 STANDING COMMITTEES

11.1.1 Standing committees shall be appointed by the HCSD on recommendation by the COS. Each committee will designate an individual to be responsible to prepare and maintain reports of conclusions, recommendations, actions taken and effectiveness of actions taken. Committee reports will be forwarded in a timely manner through appropriate channels established by the MEB or by the HCSD.

11.1.2 All committees are charged with the duty of assuring that members of the Medical Staff comply with VHA and The Joint Commission requirements applicable to their area of responsibility, including peer review. Their function and purpose, chairpersonship, membership and quorum requirements, and organization are described in specific HCSMs. Specific Committees (e.g., the Peer Review Committee) are required to present quarterly to the Medical Executive Board to describe any trends or patterns that may require further action by the Medical Staff Leadership.

11.2 MEDICAL EXECUTIVE BOARD (MEB)

11.2.1 The MEB may appoint subcommittees with specific functions, which may have representatives other than members of the Medical Staff.

11.2.2 FUNCTIONS AND RESPONSIBILITIES OF THE MEB

The functions and responsibilities of the MEB, as also delineated in health care system policies and procedures, shall include, but are not limited to:

11.2.2.1 Representing and acting on behalf of the Medical Staff in the intervals between meetings of the Medical Staff;

11.2.2.2 Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

11.2.2.3 Receiving and acting on reports and recommendations from services and committees of the Medical Staff and any other ad hoc committees, as appropriate;

11.2.2.4 Recommending actions to the Governing Body, represented by the HCSD, through the COS, regarding matters of a medical-administrative nature;

11.2.2.5 Establishing the structure of the Medical Staff, mechanism to review credentials and delineate individual clinical privileges, and organization of continuous quality management activities and mechanisms of the Medical Staff;

11.2.2.6 Establishing mechanisms for recommending to the HCSD the initiation or pursuit of corrective action when warranted;

11.2.2.7 Developing and following through on fair hearing procedures in accordance with these Bylaws and recommending termination of Medical Staff membership;

11.2.2.8 Considering and preparing recommendations for other matters relevant to the operation of an organized staff;

11.2.2.9 Fulfilling the Medical Staff's accountability for the quality of the overall medical care rendered to the patients in VAPAHCS and monitoring the level of care provided across services by clinically privileged individuals;

11.2.2.10 Participating in the development of Medical Staff and VAPAHCS policy, practice, and planning;

11.2.2.11 Reviewing the recommendations of the PSB and making recommendations to the COS and HCSD regarding staff appointments and reappointments, assignments to services, determining initial and renewal of clinical privileges, and recommending corrective action when necessary;

11.2.2.12 Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members, including the initiation of and participation in Medical Staff corrective or review measures when warranted;

11.2.2.13 Reviewing the need and formulating priorities for continuing education activities and programs for the Medical Staff in accordance with VA and state regulations, with the Associate Chief of Staff for Education;

11.2.2.14 Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and working closely with the COS when appointments are made to these committees;

11.2.2.15 Assuming the responsibility for informing the Medical Staff of all accreditation, inspection, and quality surveys conducted by groups outside VAPAHCS;

11.2.2.16 Disseminating recommendations for the protection and care of patients and others in the event of internal or external disaster;

11.2.2.17 Consulting with the COS in appointing such special or ad hoc committees, as may seem necessary or appropriate, to assist the MEB in carrying out its functions and those of the Medical Staff;

11.2.2.18 Reviewing the quality and appropriateness of services provided by contract physicians;

11.2.2.19 Holding an annual meeting of the Medical Staff;

11.2.2.20 Reviewing and revising the Bylaws, Rules, and Regulations of VAPAHCS whenever administrative or practice patterns differ significantly from those recorded here;

11.2.2.21 Assuring the participation of Medical Staff in the organization's performance improvement activities;

11.2.2.22 Ensuring there is a mechanism by which Medical Staff membership can be terminated; and

11.2.2.23 Convening a subcommittee to recommend and monitor treatment for Medical Staff members who have health issues that require treatment but do not necessarily require any limitations on clinical privileges or disciplinary action. An individual Medical Staff member who believes that another member is providing unsafe treatment is obligated to relate these concerns to the service chief of the Medical Staff member in question. In some cases, this may be due to the physician in question having a health impairment. To help prevent members from suffering from a potentially impairing condition, all staff are encouraged to make use of the services provided by Employee Health and the Employee Assistance Program (EAP) to obtain information about their health and to get information about prevention of physical, psychiatric, or emotional illness. When the CSC is aware of a member with such concerns, the CSC is expected to facilitate confidential diagnosis, treatment, and rehabilitation of Medical Staff members who suffer from a potentially impairing condition. If at any time in the diagnosis, treatment or rehabilitation phase of the process it is determined that a Medical Staff member is unable to safely perform the privileges granted, the matter is forwarded to the COS to evaluate the credibility of the matter of concern and, if appropriate, the matter is conveyed to the MEB subcommittee for any corrective action, including adherence with mandated reporting requirements. The COS will decide whether to implement or modify the recommendations of the MEB subcommittee based primarily on an assessment of whether they are sufficient to help assure that the Medical Staff member continues to receive appropriate treatment and monitoring.

11.2.3. COMPOSITION OF THE MEDICAL EXECUTIVE BOARD

11.2.3.1 The COS is the Chairperson of the MEB.

11.2.3.2 All members of the Medical Staff are eligible for membership on the MEB. Membership follows recommendation by the COS for approval by the Governing Body. Voting members of the MEB shall include the Deputy Chiefs of Staff, Associate Chiefs of Staff, CSCs, and Allied Health Service Chiefs. At meetings of the MEB, voting members who are not able to attend should designate alternates who may vote in their place. Non-voting, ex-officio members of the MEB are the HCSD and/or Associate Director, the Director for Clinical Support, representatives from Regional Counsel and Office of Quality Management, and others as designated by the COS.

11.2.3.3 Two additional voting representatives from the Medical Staff may be selected for a two-year term at the time of the annual meeting of the Medical Staff.

11.2.3.4 MEETINGS OF THE MEB

11.2.3.4.1 The MEB will meet monthly or more often if necessary to accomplish its duties. Special meetings of the MEB may be called at any time by the HCSD, the COS or by a majority of the membership of the MEB.

11.2.3.4.2 Members of the MEB or their designated alternates must be in attendance at a majority of its regularly scheduled meetings.

11.2.3.4.3 Minutes of each meeting shall be distributed throughout VAPAHCS.

11.3 PROFESSIONAL STANDARDS BOARD (PSB)

11.3. 1 The Chairperson of the PSB is nominated by the COS and approved by the HCSD.

11.3.2 Membership of the PSB shall include six to ten members of the Medical Staff. They are appointed by the HCSD.

11.3.3. The Chief, HRMS, will serve as a resource to the PSB for the purpose of establishing the wage grade and to advise and ensure proper procedures are followed in processing the appointment for employment.

11.3.4 The Medical Staff Coordinator will be an ex-officio member for the purpose of advising, assisting, and presenting proper credentialing, privileging, and any other required documents to the board.

11.3.5 Meetings of the PSB shall occur monthly or at the call of the Chairperson.

11.3.6 A quorum will consist of the Chairperson or designee and at least two other members. The CSC or designee of the practitioner being presented for discussion at a PSB meeting may attend the meeting.

11.3.7 Reports of committee recommendations will be sent to the MEB and HCSD for review and action.

11.3.8 The members of the Professional Standards Board also serve as members of the Physical Standards Board and shall review the results of medical examinations of members of the Medical Staff requested by the CSC and/or the COS. They shall recommend to the HCSD, through the COS, the appointment to the Medical Staff or the separation from it, for disability, when indicated. The chair shall be the same as that of the Professional Standards Board except when an unusual or special medical problem is under consideration and the COS wishes to designate physician(s) with appropriate expertise to supplement the membership. The Physical Standards Board shall meet at the call of the Chairperson. A quorum will consist of at least three physicians in addition to the chief of the particular service to which the member with the medical problem under consideration belongs.

ARTICLE XII PERFORMANCE IMPROVEMENT

12.1 PURPOSE AND RESPONSIBILITIES

VAPAHCS staff are expected to be involved in the overall health care system programs and processes for performance improvement, and all members are expected to contribute to their respective clinical programs for performance improvement, risk management, patient safety, and utilization review. Each service chief will:

12.1.1 Establish and maintain a mechanism to identify and routinely review complications, patient incidents, and other clinically adverse events. The results of these reviews will be systematically documented and reviewed for trends;

12.1.2 Provide a means so that all members may attend and actively participate in interdisciplinary committees for program improvement. These meetings will be conducted at least quarterly, performance measures will be trended, and minutes of meetings will be sent to the Chairperson of the MEB for appropriate follow-up;

12.1.3 Assure that admission and discharge criteria are specified and complied with for all major programs and activities within the service and that resources are utilized in a cost-effective manner;

12.1.4 Assure the activities of the service are in compliance with all regulatory and accreditation requirements; and

12.1.5 Work actively and cooperatively to promote service compliance with performance measures and other performance improvement activities.

ARTICLE XIII MEETINGS

13.1 GENERAL MEDICAL STAFF MEETING

13.1.1 The function and purpose of the general Medical Staff Meeting is to:

13.1.1.1 Review and accept the minutes of the last regular meeting and of any subsequent special meetings;

13.1.1.2 Receive the annual report by the HCSD on the state of VAPAHCS; and

13.1.1.3 Receive a summary report by the Associate Chiefs of Staff on overall Medical Staff activities including current problems affecting the delivery of patient care and implemented or planned corrective actions.

13.1.2 Minutes of the meeting shall be recorded and forwarded to the HCSD.

13.1.3 The meeting is held annually. Special meetings may be called at any time by the HCSD, COS, or MEB.

13.1.4 Attendance at the regular annual meeting and any special meetings of the Medical Staff is required. A quorum shall consist of fifty members of the full-time and part-time Medical Staff; a majority vote of those present is required to approve any motions.

ARTICLE XIV COMMUNICATION WITH THE HCS DIRECTOR

14.1 EFFECTIVE COMMUNICATION

14.1.1 To assure effective communication between the Medical Staff and the HCSD, particularly with reference to the quality of patient care and any health care system deliberations that affect the discharge of Medical Staff responsibilities, the following mechanisms shall be established:

14.2 HEALTH CARE SYSTEM DIRECTOR'S STAFF MEETINGS

14.2.1 In addition to the COS and Associate Director, all Deputy and Associate Chiefs of Staff, CSCs, Allied Health Service Chiefs, and Administrative Service Chiefs are encouraged to attend this monthly staff meeting. The staff meeting shall provide a forum for discussion of budgetary, workload, and other health care system matters affecting the discharge of Medical Staff responsibilities.

14.3 PERFORMANCE EXCELLENCE COUNCIL

14.3.1 The function and purpose of the Performance Excellence Council is to serve as an advisory body to the HCSD. It is established to assure the integration and coordination of health care system operations, policies, quality management activities, and plans. It is chaired by the HCSD and meets weekly.

14.4 REPORTS

14.4.1 Reports required by VHA or VA regulations for submission to VA Central Office and minutes shall be forwarded to the HCSD on a regular basis as specified in these Bylaws. In addition, the CSCs may communicate problems or suggestions for the correction of identified or potential problems to the HCSD through the COS at any time.

ARTICLE XV GENERAL PROVISIONS

15.1 CONFIDENTIALITY AND RELEASE OF INFORMATION

15.1.1 Confidentiality of patient-specific and health provider-specific records and information shall be protected by, and information released strictly in accordance with, Federal laws, codes, and VHA regulations:

15.2 FEDERAL TORT CLAIMS ACT (FTCA)

15.2.1 The Federal Tort Claims Act provides for civil actions against the United States for money damages "...for injury or loss of property or personal injury or death caused by the negligent or wrongful act or omission of any employee of the government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred". Excepted from this are claims arising out of certain torts, such as assault, battery, false imprisonment, libel, slander, and misrepresentation.

15.2.2 While the Federal Tort Claims Act provides a remedy against the Government, a type of statutory immunity from "individual" malpractice liability exists with respect to medical personnel of VHA; a person claiming "damages for personal injury, including death, allegedly arising from the malpractice or negligence of a physician, dentist, podiatrist, optometrist, nurse, physician assistant, expanded function dental auxiliaries, pharmacist, or paramedical (for example, medical and dental technicians, nursing assistants, and therapists) or other supporting personnel in furnishing medical care or treatment while in the exercise of such person's duties in or for the Department of Medicine and Surgery" has a possible remedy only against the Government and not against the employee. Residents, interns, and "WOC employees" (e.g., medical students), may be included provided they are working under the direct supervision of VA healthcare professionals who are duly authorized to perform said function in VAPAHCS.

15.2.3 In a situation in which the immunity statute would not apply, the immunity statute provides that the Secretary of the Department of Veterans Affairs may pay the judgment.

15.2.4 Medical Staff members have the responsibility to inform the COS of any legal actions brought against them for professional services performed outside VAPAHCS.

15.2.5 The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a Medical Staff member's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

ARTICLE XVI REVIEW AND APPROVAL OF MEDICAL STAFF POLICIES

16.1 HEALTH CARE SYSTEM MEMORANDA (HCSM)

16.1.1 Medical Staff policies and procedures applicable to two or more clinical services or interfacing with administrative or allied health services shall be published as HCSM for distribution to all staff members, COS, and HCSD. HCSM are reviewed, revised as necessary, and updated at least every three years. They shall not conflict with each other, with these Medical Staff Bylaws, Rules, and Regulations, or with VA regulations or policies.

16.2 SERVICE SPECIFIC POLICIES AND PROCEDURES

16.2.1 Medical Staff policies and procedures applicable to the functions of a particular clinical service shall be reviewed and revised as necessary.

ARTICLE XVII ADOPTION, AMENDMENT, OR REVISION OF THE MEDICAL STAFF BYLAWS, RULES, AND REGULATIONS

17.1 APPROVAL, ADOPTION, AMENDMENTS, REPEALS, OR REVISIONS REQUIREMENTS

Approval and adoption of the Medical Staff Bylaws, Rules, and Regulations shall occur upon recommendation of the active Medical Staff at any regular or special meeting of the Medical Staff at which a quorum is present and shall thereafter replace any previous Bylaws, Rules, and Regulations. A simple majority vote of eligible members present at a Medical Staff meeting is necessary to approve, adopt, revise, amend, or repeal the Bylaws, Rules, and Regulations. They shall become effective when approved by the HCSD. Approval, adoption, amendments, repeals, or revisions of these Bylaws, Rules, and Regulations of the Medical Staff shall be approved by action of both the Medical Staff and the HCSD. Neither may amend these Bylaws unilaterally.

17.2 REVIEW INTERVAL

The Bylaws, Rules, and Regulations shall be reviewed by a committee of Medical Staff members at least every three years. The members of this committee are appointed by the COS. Revisions will be entered to reflect the health care system's current policies with respect to Medical Staff organization and functions, and shall be approved as provided under paragraph 17.1.

17.3 PROCEDURES FOR AMENDMENTS TO BYLAWS

Proposed amendments to the Bylaws, Rules, and Regulations may be submitted in writing to the COS by any service chief or member of the Medical Staff.

17.4 NOTIFICATION OF REVISIONS

When revisions are made to the Bylaws, Rules, and Regulations, or VHA policies and health care system policies relating to performance of Medical Staff members who have delineated privileges, they shall be informed in writing of the revision(s) and provided with revised texts of the written materials upon request.

17.5 CONFLICTS WITH VHA REGULATIONS AND POLICIES

These Bylaws, Rules, and Regulations, amendments, and revisions shall not conflict with VHA regulations; if such conflict is determined to exist, VHA regulations shall prevail until the Bylaws, Rules, and Regulations can be brought into compliance. The Rules and Regulations of each service shall not conflict with the Medical Staff Bylaws, Rules, and Regulations or VHA regulations.

RULES AND REGULATIONS

SECTION R.1 GENERAL

R.1.1 The Rules and Regulations relate to the role and or responsibility of members of the Medical Staff with clinical privileges in the care of inpatients, emergency care patients, and ambulatory care patients as a whole or to specific groups as designated.

R.1.2 Rules and regulations of services will not conflict with each other, the Bylaws, Rules, and Regulations and policies of the Medical Staff, or requirements of the Governing Body, as expressed in policies of VHA or Federal Government.

SECTION R.2 PATIENT RIGHTS

The care, treatment, and rehabilitation services will be modified to meet the patient's needs taking into account disease severity and disabilities. Patients and their family members, or designated representatives, have the right to:

R.2.1 Be given free access to information on patient's rights and be informed as to the process of handling patient complaints. Be informed about, consent to, or refuse the recommended treatment to the extent permitted by law, and to be informed of the medical consequences of the patient's action;

R.2.2 Be treated with dignity as an individual, with compassion and respect, reasonable protection from harm, and appropriate privacy. Care should include consideration of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness. Privacy is not solely privacy of the patient's body, but the privacy of disclosure of patient information. All verbal or written disclosures of facts regarding a patient will be handled in accordance with VHA policies regarding the release of information;

R.2.3 Receive, to the extent the patient is eligible, prompt and appropriate treatment for physical or emotional disorders or disabilities, in the least restrictive environment necessary for treatment, free from unnecessary or excessive medication. In settings where a physician's history and physical (H&P) exam is standard of care, this treatment will be under the medical direction of a licensed physician who is a member of the Medical Staff;

R.2.4 Communicate with those responsible for the patient's care and receive from them adequate information concerning the nature and extent of the clinical problem, the alternatives and recommended course of treatment, and the prognosis; be informed as to the nature and purpose of any medical treatment or technical procedures performed on the patient, as well as to know why and by whom such medical treatment and/or such recommended procedures are to be carried out; to know the identity of the physician primarily responsible for the patient's care; and to expect adequate instruction in self-care in the interim between visits to VAPAHCS or to the physician;

R.2.5 Participate in decisions of an ethical nature and receive information and assistance in formulating advance directives and in the appointment of a surrogate to make health care decisions for them;

R.2.6 Receive information about adverse events that materially affect their care as per the requirements of the current HCSM, "Disclosure of Adverse Events to Patients;"

R.2.7 Refuse treatment to the extent permitted by law, and to be informed of the medical consequences of the patient's action; and

R.2.8 Receive any information regarding human experimentation or research or education projects affecting their health care, and to refuse to participate in experimental or research protocols, without jeopardizing care.

SECTION R.3 INFORMED CONSENT

R.3.1 It is VAPAHCS policy that patients may accept or refuse treatment offered to them, written consent is required before any major treatments or procedures are initiated, and the patient is clearly informed regarding the nature of the procedure or treatment to be undertaken, the risks and benefits of the treatment, alternatives to consider, and the expected outcome if the treatment is declined.

R.3.2 The practitioner who has primary responsibility for the patient or who will be performing the procedure/treatment is responsible for informing the patient and for obtaining the written consent in the presence of a qualified witness. Documentation of the informed consent and the informed consent discussion must be made in the medical record with all the considerations described in the most current health care system memorandum.

SECTION R.4 GENERAL RESPONSIBILITY FOR CARE

R.4.1 CONDUCT OF CARE

R.4.1.1 The management of the patient's general medical condition is the responsibility of a qualified physician member of the Medical Staff.

R.4.1.2 The same quality of patient care will be provided by all individuals with delineated clinical privileges, within and across all services of this health care system and between all staff members who have clinical privileges.

R.4.2 EMERGENCY SERVICES

R.4.2.1 Emergency care in this health care system will be at Level II.

R.4.2.2 Emergency services will be guided by written policies, procedures, and guidelines appropriate to Level II.

R.4.2.3 Physician staffing will be consistent with the Level II designation.

R.4.2.4 Evaluation of patient applicants requesting emergency care will be according to need as defined by written triage guidelines. Those with emergent or urgent conditions will be treated regardless of legal eligibility for care in a VA facility.

R.4.2.5 Patients without emergent or urgent care needs who are not legally eligible for care will be referred to appropriate facilities.

R.4.3 ADMISSIONS

R.4.3.1 Only members of the Medical Staff with clinical privileges will be permitted to admit patients. Housestaff admit patients under supervision of the Medical Staff.

SECTION R.5 PROFESSIONAL EDUCATION

R.5.1 Medical Staff members shall participate in a program of continuing medical education designed to keep them informed of significant new developments in medicine.

R.5.2 Medical Staff education will include health care system based programs that are planned, scheduled in advance, and held on a continuing basis, and educational opportunities held within or outside the health care system that are sponsored by educational institutions, societies, or organizations approved for Continuing Medical Education (CME).

R.5.3 Documentation of these activities will be kept in order to evaluate scope, effectiveness, attendance, and the amount of time at such effort.

R.5.4 This continuing education must be documented in the Medical Staff member's file. Departmental meetings at which continuing education is conducted may be used, but they must be documented and approved for appropriate CME credit.

SECTION R.6 SUPERVISION

R.6.1 Members of the Medical Staff, housestaff, allied health professionals, and medical students participating in the care of patients shall make appropriate entries in the medical records consistent with their delineated privileges, licensure limitations, and health care system policy. The Medical Staff member responsible for the patient shall document supervision of care provided by housestaff, allied health professionals, and medical students in progress notes in the medical record as frequently as deemed clinically appropriate.

R.6.2 Entries in the medical record requiring countersignature by Medical Staff or the supervising resident are listed below by category of personnel making the entry:

R.6.2.1 All orders in the medical record written by medical, dental, and podiatry students require the countersignature of a physician, dentist or podiatrist who possesses an MD, DO, DDS, or DPM degree or its equivalent and a valid state license to practice medicine.

R.6.2.2 Prior to high-risk interventions, the patient histories and physical exams written by PAs or RNPs shall be amended as necessary and countersigned by a licensed physician.

R.6.2.3 Entries made in the medical record by students cannot be accepted in lieu of required entries by residents or Medical Staff members.

R.6.3 The medical record must document that a member of the Medical Staff has seen the patient and concurs with the diagnosis and treatment plan. The staff member must also demonstrate continued supervision of the resident, RNP, CNS, ESRN, CRNA, or PA by appropriate documentation on the chart.

R.6.4 The Medical Staff member responsible for the patient's care shall document supervision of care and treatment provided to patients by members of the housestaff and allied health professionals in progress notes of the patient's medical record as frequently designated by the current version of VHA Resident Supervision Handbook.

R.6.5 Adverse events from peer review, tort claims, or compliance reviews where the findings reveal a lack of supervision of residents or allied health providers must be forwarded by Quality Management to the COS. If the COS agrees that inadequate supervision was a contributing factor, then the case will be forwarded to the CSC of the Medical Staff member who was responsible for the patient. When the case involves inadequate supervision of a resident, the COS will also notify the ACOS for Education and the service chief will notify the VA residency program director.

SECTION R.7 ADMISSIONS, DISCHARGES, AND PATIENT CARE

R.7.1 VAPAHCS can accept only those patients for care and treatment who are medically and legally eligible as defined by current law and by policies of VHA and VAPAHCS. For humanitarian reasons, in the case of a true medical emergency, medical care shall be rendered to a non-eligible patient until such time as the patient's condition is stabilized to the degree the patient can be either transferred to another health care facility or sent home.

R.7.2 Admitting to a setting where a physician's admission H&P exam is standard of care is restricted to appropriate housestaff or licensed physicians (MDs or DOs), who are appointed to attend patients. Patients may be denied treatment only by professionals who have the above described admitting responsibilities.

R.7.3 Except in an emergency, no patient shall be admitted until after a provisional diagnosis has been stated on the medical record. The Medical Staff members will examine and make the proper disposition of all eligible applicants.

R.7.4 Final authority for admission and assignment to a service rests with the admitting medical professional. When an admission to a particular specialty service is considered to be necessary by the admitting Medical Staff or housestaff, the service should be contacted for consultation.

R.7.5 Upon admission to inpatient care at VAPAHCS, each patient shall be assigned to the clinical service or section deemed most appropriate for the care and treatment of the condition for which hospitalization is required.

R.7.6 In acute care settings, an H&P examination and initial plan of care shall be entered and signed by a physician Medical Staff member or housestaff within 24 hours of admission. For sub-acute and long term care settings, see the most recent HCSM addressing medical record requirements for these settings. If a complete medical H&P examination of the patient has been performed at the facility within 30 days prior to the patient's admission, then a H&P need not be conducted within 24 hours of admission, provided any changes are recorded at the time of admission and a cardiopulmonary system physical is conducted within 24 hours after admission.

R.7.7 The admission and care of a dental or podiatric patient shall be the responsibility of a physician member of the Medical Staff. The physician shall be responsible for the care, and/or supervision of the care provided by housestaff, of any medical problem present on admission or that may arise during the rest of the patient's hospitalization.

R.7.8 TRANSFER OF PATIENTS

R.7.8.1 Patients shall not be transferred from one bed service to another or out of an ICU or PACU without a signed order by the Medical Staff or housestaff physician.

R.7.8.2 Transfers from one bed service to another will be accomplished only by mutual agreement of the bed services involved.

R.7.8.3 There must be a transfer note entered by the transferring Medical Staff Member or housestaff. It will be a concise recapitulation of the hospital course to date and will include a current list of medications to assist the receiving physician who assumes responsibility for the continuity of inpatient care. The receiving physician must enter a note of acceptance that includes a plan of care.

R.7.8.4 All orders will automatically be discontinued on moving from one service to another or when the patient goes to the operating room.

R.7.8.5 A ward clerk or a nurse will be responsible for promptly notifying the receiving staff professional as soon as a new patient has arrived on the ward.

R.7.9 Each patient shall be the responsibility of a member of the Medical Staff. Such Medical Staff member shall be responsible for medical care and treatment, the prompt completion and accuracy of the medical record, necessary special instructions, transmitting reports of the condition of the patient to the referring Medical Staff member, and communicating to relatives of the patient, as indicated. Although the day-by-day treatment of the patient, which includes entering patient care orders, may be delegated to the housestaff, the responsibility for patient care rests with the Medical Staff member. Whenever these responsibilities are transferred to another staff member or service or to another health care facility, an order covering the transfer shall be entered in the medical record.

R.7.10 Patients shall be discharged only on order of the Medical Staff or housestaff. Insofar as possible, discharge orders will be written 24 hours in advance of the contemplated departure of the patient. No discharge will be affected without adequate provisions for continued follow-up care.

R.7.11 Plans should be made to discharge patients before 11:00 a.m., if possible.

R.7.12 Should a patient leave against the medical advice (AMA) of the attending or housestaff or without following the proper discharge procedures, notation of this incident shall be made in the patient's medical record. The appropriate staff shall be notified promptly for completion of administrative details. If for some reason, the attending staff professional desires not to discharge the patient AMA under the latter circumstances, a notation of this should be made on the clinical record.

R.7.13 When patients are admitted primarily for dental or podiatric problems, the dentist or podiatrist will be responsible for documenting their part of the patient's H&P examination related to their disciplines within 24 hours of the patient's admission to VAPAHCS.

R.7.14 A podiatrist or dentist with clinical privileges may, with the concurrence of an appropriate physician member of the Medical Staff, initiate the procedure for admitting a patient. This Medical Staff member shall assume responsibility for the overall aspects of the patient care throughout the stay. Patients admitted for dental or podiatric care must be given the same basic medical appraisal as patients admitted for other services. A physician member of the Medical Staff must be responsible for the care of medical problems of hospitalized podiatric or dental patients.

R.7.15 Dental and oral and maxillofacial surgery privileges (in the operating room) must be specifically defined in the same manner as all other surgical privileges and may be exercised only under the overall supervision of the Chief, Surgical Service.

R.7.16 Blood drawn for cross-matching and subsequent transfusion of blood products must be according to established policy of the Transfusion Committee as documented in the most recent HCSM.

SECTION R.8 PATIENT ORDERS

R.8.1 All medical orders for patient care must be entered in the medical record. Handwritten orders (typically utilized during computer downtime) must be legible, include a written date, and signed by members of the Medical Staff, physician housestaff, or RNP issuing the order, before the instructions are executed. Handwritten orders must not contain any unapproved abbreviations.

R.8.2 All orders for treatment shall be entered and signed by a member of the Medical Staff or housestaff or by other individuals within the authority of their clinical privileges or specified duties.

R.8.2.1 Verbal orders must be consistent with the most recent HCSM on verbal orders and are to be signed within 24 hours by the provider or any licensed physician involved in the care of the patient. Verbal orders will be immediately read back to the provider for confirmation.

R.8.4 Verbal telephone orders shall be acceptable only in emergent situations or circumstances such as evenings, nights, and weekends, when the medical professional directly involved with a given patient's care is outside the building and the telephonic orders are the most practical and expeditious means of continuing that patient's care at that time. Telephone orders shall be immediately read back to the provider for confirmation.

R.8.5 Orders which are not understandable will not be carried out until clarified by the author. This includes orders containing abbreviations and symbols referenced on the "Do not use" list.

R.8.6 ORDERS AND MEDICATIONS

R.8.6.1 With few exceptions, inpatient medication orders will automatically expire in 28 days. Longer time limits will be allowed only in settings specifically listed in HCSM, "Automatic Stop Order Policy in Hospitalized Patients." The Medical Staff Member, housestaff member, or allied health provider with prescription privileges will be notified prior to the expiration date.

R.8.6.2 Drugs used shall meet the standards of the United States Pharmacopoeia, National Formulary, New and Non-Official Drugs, with the exception of drugs for clinical investigation. Investigational drugs may be used only on approved protocols which have cleared the Human Subjects and Research Committees or after review by the Medication Management Committee (MMC), which have been approved by VHA for clinical care and for which the patient's (or legal representative's) signature has been obtained on an approved

consent. Any requests for exception to this rule shall be justified in writing, reviewed, and recommended to the COS by the MMC.

R.8.6.3 Automatic stop orders shall be adhered to in accordance with current health care system policy. An automatic stop order does not apply when the number of doses in an exact period of time is specified.

R.8.6.4 Patients are discouraged from bringing medications into the health care system. Patients who bring their own medications into the health care system shall either have it sent home with a relative or mailed home by pharmacy. If the patient is homeless, medication shall be stored by pharmacy until officially discharged, according to the current HCSM, "Patient Medication Brought to the Health Care System."

R.8.6.5 Self-administration of drugs by patients is not allowed except in specific units identified in the most recent HCSM, "Self-Medication Program," when specifically ordered by the responsible medical professional. It is reserved for patients for whom self-administration of drugs is important for their overall medical care.

SECTION R.9 GENERAL RULES REGARDING SURGICAL CARE

R.9.1 Every attempt should be made to perform operations on an outpatient, or if not possible, on a day-of-surgery admission basis.

R.9.2 The H&P examination should be recorded prior to the time stated for a surgical procedure. If they are not, the surgery shall be delayed to allow time to complete this documentation unless the surgeon states in writing in the medical record that such delay would constitute a hazard to the patient. Outpatient surgery requires an H&P that is less than 30 days old. This H&P must be written in enough detail to allow the formulation of a reasonable picture of the patient's clinical status. This includes sufficient information from the patient's history and the surgeon's exam to document why surgery is appropriate. A brief assessment and plan are also essential. If the indications for surgery have changed, a statement describing these changes must also be included in this addendum to the initial H&P.

R.9.3 Major surgical operations, other than emergency procedures, shall not be performed until adequate clinical data, which may include radiology and laboratory results, are recorded on the chart.

R.9.4 Surgical operations and other invasive diagnostic and therapeutic procedures shall be undertaken only when there is prior, informed voluntary consent of the patient or, where appropriate, through the patient's legal representative. The written informed consent(s) shall be in the medical record before the surgical procedure has begun.

R.9.5 Written and signed informed surgical consent shall be obtained within 30 days prior to an operative procedure by the responsible staff professional except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained

due to the condition of the patient. In emergencies involving an unconscious patient whom consent for surgery cannot be immediately obtained from next of kin, these circumstances should be fully explained in the patient's medical record by the operating staff surgeon. A second physician member of the Medical Staff must be consulted for concurrence. VA forms will be used and the name of the operating surgeon and the second (consulted) Medical Staff member will be on the consent form.

R.9.6 All tissues and materials removed during surgery shall be sent to the Pathology and Laboratory Medicine Service for examination or disposition as is necessary to arrive at pathological diagnosis. The specimen shall be adequately labeled as to patient's name and tissue source and shall be accompanied by a tissue examination form with pertinent identification and clinical information. A signed report will be issued to document the pathologic diagnosis. All tissue shall remain the property of the health care system under the custody of the Chief, Pathology and Laboratory Medicine Service.

R.9.7 The operating surgeon shall have a qualified physician or oral surgeon as the assistant for all major operations in the upper abdomen or thorax. This assistant must be another surgeon.

R.9.8 Medical students may be permitted to perform minor surgery such as closure of minor wounds and incisions, minor excision of cysts, etc., under the direct supervision of a qualified physician.

R.9.9 There must be evidence in the medical record of a pre- and a post-anesthesia visit by a member of the anesthesia care team. A post-anesthesia visit shall be made during the time the patient is in the post-anesthesia care unit. If possible, a second visit should also be made after the patient has left the post-anesthesia care unit. The PACU note will describe the presence or absence of anesthesia-related complications.

R.9.10 The release of every patient from the post-anesthesia recovery room shall be in accordance with the recovery room policy.

R.9.11 Operative reports must be dictated or entered in the medical record immediately after surgery. They should contain a description of the findings, technical procedures used, specimens removed, pre-operative diagnosis, post-operative diagnosis, type of anesthesia, estimated blood loss, and name of the primary surgeon and any assistants. A post-procedure note should be entered immediately after completion of the surgery if the operative report is not available.

R.9.12 Prior to the start of invasive procedures, a final verification process (time out) will be performed to confirm the correct patient is being treated, procedure, site, and proper implants are available.

SECTION R.10 SPECIAL TREATMENT SERVICES

R.10.1 Treatment procedures that require special justification:

R.10.1.1 The physician must comply fully with the physical restraint and/or seclusion policy for that specific patient care setting;

R.10.1.2 Electroconvulsive therapy is not performed on children or adolescents in this facility;

R.10.1.3 Psychosurgery is not performed in this facility;

R.10.1.4 Behavior modification procedures that use aversive conditioning are not done in this facility; and

R.10.2 Interprofessional treatment plans on the psychiatric and alcohol treatment units are initiated and monitored by Medical Staff in charge of each treatment team. Treatment plans initiated or monitored by residents are supervised by Medical Staff members.

SECTION R.11 CONSULTATIONS

R.11.1 The Medical Staff through its CSCs shall assure that appropriate consultations will be requested. Any member of the Medical Staff may be requested to provide consultation within the Medical Staff member's area of expertise. Consultation is urged for the following situations:

R.11.1.1 When the patient is not a good risk for an operative procedure;

R.11.1.2 Where the diagnosis remains obscure after ordinary diagnostic procedures have been completed;

R.11.1.3 Where there are significant differences of opinion as to the best choice of therapy;

R.11.1.4 In unusually complicated situations where specific skills of other practitioners may be helpful;

R.11.1.5 When specifically requested by the patient or his family and with concurrence by the attending physician; and

R.11.1.6 For all patients who have attempted suicide or who have had self administered chemical overdoses, psychiatric consultation will be provided.

R.11.2 Each consultation report should contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record, and shall be a part of the medical record.

R.11.3 A consultant must be well qualified to give an opinion in the field in which an opinion is sought. The status of a consultant is determined by the Medical Staff on the basis of the individual's training and experience and competency. Residents or Fellows may act as consultants when approved by the CSC, but all consultation notes should document the involvement of the appropriate Medical Staff member on the consulting service.

R.11.4 A satisfactory consultation includes an examination of the patient and the medical record. When operative procedures are involved, the results of the consultation, except in an emergency, shall be reported prior to the operation.

R.11.5 The CSCs will make certain that members of their staff provide timely consultation as needed.

R.11.6 Consultation should be initiated by the Medical Staff member, housestaff, or RNP. Other health care providers may request a consultation by a physician only after obtaining approval from a member of the Medical Staff and must submit the request in the approving Medical Staff member's name. The consultation request should be in electronic format or in writing on the appropriate form and addressed to the specific service or person. Consultation requests should clearly set forth the problem and provide information requested.

R.11.7 Consultation should be requested for valid medical or educational reasons. All resource intensive specialized tests, such as CT scans, MRI's, Angiograms, Myocardial Perfusion Scans, Echocardiography, and Holter monitoring, must be approved by a physician with the supervising physician's name included on the consult request.

R.11.8 Responding to Consultation Requests

R.11.8.1 CSCs or Subspecialty Section Chiefs are responsible for establishing policies associated with responding to consultation requests rests. Basic philosophy should be to provide consultation with a high level of professional competency, efficiency, and promptness both for service to the patient and for educational purposes. Fellows or advanced residents may respond to consultation requests. The person actually examining and writing the consultation advice should sign the consult note, thus fixing the medical and legal responsibility. All consultation notes should document the level of involvement of the appropriate staff person.

R.11.9 Appropriate medical ethics should be followed in consultations. The findings and opinions of the consultant should be limited to the clinicians involved. Patients should not be apprised or advised by the consultant except with the attending staff's prior knowledge and consent.

R.11.10 If a nurse or any other health care professional has any reason to doubt or question the quality of care provided to any patient and feels that appropriate consultation is needed and has not been obtained, the health care professional shall direct said question(s) to the attending Medical Staff member. If after this, the health care professional still feels their

question(s) has not been resolved, the matter should be called to the attention of a supervisor who will attempt to solve the problem through appropriate channels. If not resolved, final disposition of such concerns shall be made by the COS.

SECTION R.12 MEDICAL RECORDS

R.12.1 Members of the Medical Staff or housestaff who have admitted or evaluated a new patient must record sufficient information in the medical record to identify the patient, support the diagnosis, and justify the treatment. The basic medical appraisal shall include an admission history, a physical examination, an overall medical evaluation, and a provisional diagnosis.

R.12.2 Records will be created and maintained following the format approved by VHA or as modified at VAPAHCS after approval by the Medical Records Review Committee (MRRC).

R.12.3 Each consultation report shall be produced electronically, handwritten or typed and contain an opinion by the consultant that reflects, where appropriate, an actual examination of the patient and the patient's medical records.

R.12.4 Pertinent progress notes shall be made by members of the housestaff and allied health professionals. Documentation, using established criteria of attending supervision of housestaff, must be included in every record.

R.12.5 Progress notes shall give a pertinent chronological report of the patient's course in the health care system and should reflect any change in condition that results in a change of treatment or diagnostic procedure plans. They shall be complete; they must be dated; and, when appropriate, they should be timed. They shall be recorded at a frequency appropriate to the condition of the patient.

R.12.6 Reports of procedures, tests, and results shall be documented in the medical record and evidence that such information was used in determining patient care is required.

R.12.7 Progress notes shall be written by housestaff as frequently designated by the current version of VHA Resident Supervision Handbook. All entries shall be dated and authenticated.

R.12.8 The attending Medical Staff member or housestaff shall write into the medical record of each patient as soon after admission as possible the following:

R.12.8.1 The provisional diagnosis or recognized clinical problems;

R.12.8.2 The initial note stating the cause of hospitalization, clinical findings, and the course of treatment contemplated; and

R.12.8.3 Each clinical event shall be fully documented as soon as possible after its occurrence. A complete H&P examination shall be written or dictated within 24 hours after admission in all settings where a physician's admitting H&P exam is standard of care.

R.12.9 Symbols and abbreviations may be used only as allowed in the most recent HCSM on the use of abbreviations in the medical record. The Medical Staff member must comply with the current HCSM, "Abbreviations, Acronyms, or Symbols in Patient Medical Records."

R.12.10 The latest editions of Current Medical Information and Terminology, Current Procedural Terminology of the American Medical Association, and Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association shall be used to provide uniform disease and operation terminology.

R.12.11 Laboratory, radiology, EKG, pathology, and other essential reports must be incorporated into the medical record within 24 hours.

R.12.12 Medical records will be completed insofar as possible at the time of discharge, including signature, discharge note, diagnosis, operations, and/or procedures. Discharge summaries must be dictated within 24 hours after discharge. In the event of death, a summation statement or a final progress note indicating the reason for admission, the course in the hospital, and the events leading to death should be recorded in the patient's chart immediately.

R.12.13 A Discharge Summary shall be prepared at each termination of hospitalization. It must include the final diagnosis, operations or procedures performed, and a concise recapitulation of the reason for admission, significant findings, and treatment rendered. It should also include the condition of the patient at discharge, expected period of convalescence if required, recommendations for follow-up treatment, medications given, and all instructions provided to the patient (including diet and activities). A list of the medications, the dose prescribed, and the total quantity prescribed, shall be entered in the medical record. A medication list and the discharge medications shall be given to the patient or a responsible adult with instructions on how the medication is to be taken and what the possible side effects might be.

R.12.14 For settings where a physician's admitting H&P is required, a physician member of the staff shall be responsible for the completed medical record for each patient. The medical record should include: identifying data (including age and sex); medical history, chief complaints, history of present illness, personal history, and family history; physical examination; provisional diagnosis; current medications, a clear indication for all medications ordered, allergy information, all diagnostic laboratory and radiological tests; medical treatments or procedures; surgical procedures, preoperative diagnosis, operative reports, and pathological findings; special reports, such as consultations; progress notes including condition on discharge (discharge note) and final diagnosis; and final summary at discharge,

follow-up and preliminary results of the autopsy when performed. No medical record shall be closed until it is complete, except upon the recommendation of the Chairperson, MRRC, using established criteria.

R.12.15 All new patients or patients readmitted 30 or more days following discharge from the prior admission shall have a complete H&P examination unless being admitted to a setting that does not require an admission H&P examination.

R.12.16 Final diagnoses, operations, or procedures must be written using terminology consistent with the latest directives from VA Central Office.

R.12.17 Final necropsy reports must be made part of the patient's medical record within 30 days. The initial report should be completed within 72 hours.

R.12.18 A contemporaneous progress note will be completed for each episode of outpatient care with review and signature within three working days of its entry into the record.

R.12.19 A medical record is determined to be complete when all required contents are assembled and authenticated as previously outlined. All summaries are to be signed by the attending physician. A medical record, which remains incomplete more than 30 calendar days following discharge, is considered a delinquent record.

R.12.20 All entries in the medical record shall be dated, typed, and identified by signature and title.

R.12.21 Signature stamps may be used only in conjunction with the personal signature or initial for legibility in the medical record.

R.12.22 Access to all medical records of all patients shall be afforded to staff members for bona fide study and research while preserving confidentiality in accordance with the privacy Act of 1974 and the federal laws on alcohol, drug abuse, and patients with AIDS.

R.12.23 All records are the property of VAPAHCS and can be removed from the premises only under court order, statute, subpoena, or conditions consistent with VA regulations, such as designated contracting officials.

R.12.24 Staff members who are chronically delinquent and fail to complete their assignments, including records, will be subject to disciplinary actions. Furthermore, such negligence may become part of their re-privileging information.

R.12.25 Appropriate documentation in the medical record includes information required for third party billing and must be made in accordance with the considerations described in the HCSM, "Medical Record Documentation."

SECTION R.13 QUALITY OF PROFESSIONAL SERVICES

R.13.1 Ambulatory Care services shall meet the same standards of quality as those that apply to inpatient care, given the inherent differences between inpatients and outpatients with respect to their needs and modes of treatment.

R.13.2 The quality of care provided in the outpatient service will be measured as part of the health care system's Quality Management Program.

R.13.3 Evaluation of the efficiency and effectiveness of ancillary patient services shall be carried out systematically in an objective manner and appropriately documented. Overall responsibility for the quality of medical care rests with the Medical Staff.

R.13.4 The quality of patient care shall be evaluated by members of the Medical Staff and other members of the professional staff directly responsible for patient care.

R.13.5 Evidence of the quality of patient care provided in the health care system shall be demonstrated by measurement of actual care against specific criteria. These criteria must be established or adapted by the Medical Staff for evaluation of all physician-directed care and by non-physician health care professionals for evaluation of those aspects of patient care that they provide.

R.13.6 Criteria must be explicit and measurable and must reflect the optimal level of care that can be achieved through current medical and related health science knowledge.

R.13.7 Quality of care reviews should include expected patient outcomes of the result of intervention by physicians and other health care professionals.

R.13.8 If review indicates an inappropriate pattern of patient care, action must be taken to correct the problem. Such actions must be specific to the problem and may include education or training programs, amended policies or procedures, increased or realigned staffing, provision of new equipment, or facilities or adjustments in staffing privileges.

R.13.9 To demonstrate that corrective action has been effective, follow-up studies must be conducted.

R.13.10 Patient care activity must be evaluated and its results reported to the MEB. The evaluation activity shall be continuous and shall be comprehensive of conditions and problems treated and procedures performed. The results of quality of care evaluations shall be specifically reflected in other quality protective functions of the Medical Staff, including appointment and reprivileging of Medical Staff members. Control of the utilization of VAPAHCS resources, the continual monitoring of practice within the professional staff, and the provision of continuing professional education is the responsibility of the Medical Staff in cooperation with the health care system management.

SECTION R.14 HANDLING OF AUTOPSIES

R.14.1 In the interest of improving patient care and professional knowledge, every member of the professional staff is expected to participate in securing autopsies on all deaths. No autopsy shall be performed without consent of the patient's next of kin or legally authorized agent. In every case of death in the health care system, the Medical Staff member or housestaff member should contact the patient's next of kin or legal agent and request permission to perform an autopsy and then document the response in the medical record.

R.14.2 Consent for autopsies will be obtained by signature of the next of kin on the appropriate form, including any limitation imposed by the next of kin. Permission for donation of any organ or tissue would be included. The physician staff will provide information regarding clinical diagnosis and concerns to the pathology staff prior to the autopsy, specifically including any infection hazards.

R.14.3 Autopsy examinations are strongly encouraged in the following deaths:

R.14.3.1 Deaths in which an autopsy may help to explain unknown and unanticipated medical complications or deaths in which the cause is not known with certainty on clinical grounds;

R.14.3.2 Cases in which an autopsy may help allay concerns of the family and provide reassurance to them;

R.14.3.3 Unexpected and unexplained deaths occurring during or following any dental, medical, or surgical diagnostic and/or therapeutic procedures;

R.14.3.4 Sudden, unexpected, or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction; and

R.14.3.5 Deaths that are subject to the County Coroner's jurisdiction. The County Coroner may waive jurisdiction and permit or request the autopsy to be performed at VAPAHCS. The Coroner will usually request a copy of the completed report. Cases in which the Coroner must be notified at the time of death are:

R.14.3.5.1 Persons dead on arrival at VAPAHCS;

R.14.3.5.2 Deaths occurring in VAPAHCS within 24 hours of admission; and

R.14.3.5.3 Deaths in which the patient sustained or apparently sustained an injury while hospitalized that might have contributed to the patient’s demise.

R.14.3.6 Family members or legal guardians may request copies of the autopsy examination. The Health Information Management Section of the Office of COS will handle such requests.

R.14.3.7 It is expected that a copy of the gross findings will be completed in four working days and the entire autopsy completed in 30 days unless extenuating circumstances such as special toxicological studies, special fixing and staining pertain.

R.14.3.8 As part of the Quality Management Program, a copy of the autopsy results will be sent to the treating service, and findings from autopsies may be used as a source of clinical information in seeking to continually improve patient care at VAPAHCS.

SECTION R.15 DISASTER PLAN

R.15.1 Mass casualty assignments for physicians may require assignment to posts with the health care system or at auxiliary facilities or to mobile casualty stations. It is the physician's responsibility to report to the assigned station when needed. The COS and HCSD will coordinate activities and direction. In cases of evacuation of patients from one section of the health care system to another or evacuation from health care system premises, the COS will authorize the movement of patients as directed by the HCSD or designee. All policies concerning patient care will be the responsibility of the COS or HCSD.

SECTION R.16 CONFLICTING RULES AND REGULATIONS

R.16.1 These Rules and Regulations are further specified in HCSM and VA regulations. The rules and regulations of each service shall not conflict with each other, the Bylaws, Rules, and Regulations of the Medical Staff, or VHA and health care system policy.

ADOPTED BY THE MEDICAL STAFF OF THE VA PALO ALTO HEALTH CARE SYSTEM,
Palo Alto, California 94304

_____ DATE: _____
Lawrence Leung, M.D., Chief of Staff
Chairman, Medical Executive Board

APPROVED BY THE HEALTH CARE SYSTEM DIRECTOR

_____ DATE: _____
Elizabeth Joyce Freeman, Director